Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Month Year 58 AM MELCHOIR JOANN MAY 2008 /Medical 22 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death AUTIMORE N/A HOPLINS BAYVIEW MEDICAL Social Security Number If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) Months Days 1 □ M XXF Director 212-34-5031 70 Nov. 16,1937 Pennsylvania Usual Residence of Decedent 10a. State Show 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at Director 1X Yes 2 □ No <u>Maryland</u> N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5026 Delegrange Avenue 21205 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No ۵ م 3 Widowed 4 □ Divorced Specify: Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Bar Maid 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental George Prettyman Orpha May John 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau Raynor Green (Son) 7402 Regal Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Other (Specify) 4 Donation filltop Service Corp. 5/27/2008 Towson, Maryland Signature 22 Name and Address of Facility Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, 1 f Dundalk, MD 21222 Inter the disease, or complications that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS 7Medical Due to (or as a consequence of): Examiner 9SPIRATION Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. burial physician Physician/Medical the IF FEMALE for use 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 4☐Pregnant at time of death Division or Vital Records, P.O. 9 Unknown 9 Unknown à signed to be detail Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has autopsy perform 1 Yes 2 1 10 10 Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After J the Hospital or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours af To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DE3-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE M.D. 4940 EASTERN AVENUE MATIVO 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 06:44 a<sup>M</sup> 05 24 2008 Virginia Mary Mulhollen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kingsville Baltimore 8006 Yellowstone Road Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours West Virginia 1 □ M 2 💢 F 03/10/1916 92 Director 219-66-5345 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it is Medical Evanian in a matter at 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 🔀 No Director MD Baltimore Kingsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21087 8006 Yellowstone Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Yes. Give Specify: þ Specify: White 3 X Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Winifred D. O'Donnell ၉ Patrick S. Casey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau Patricia M. Hauer-Sibayan, Dtr. 8006 Yellowstone Road, Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 05/29/2008 Baltimore, Maryland Gardens of Faith 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses Marandria 38 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nonth Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical signed by the attending I IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mg Month Day 5 Other (specify) ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 Tes within 24 hours after death.

To the Funeral Director; After this certificate has been s completely filled in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or A 24 hours after 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) To the I within 2 and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

10

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Philadelphia Ld. SK#106 Bult. MD 21237

08-03565

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| onald Neal   | State of Maryland / Departmer   | it of Health and Mental Hygic<br>e of Death   | ZIIII 1700 C  |
|--|---|---|---|
|  | Registrar  1. Decedent's Name (First, Middle,Last)  | 2. D  | Reg. No. ate of Death 3. Time of Death  |
| Medical Examiner   | Donald Neal   |   | onth Day Year 0150 hrs  |
| £  | 4a. Facility Name (if not institution, give street and number)  12304 Melody Turn   | 4b. City, Town, or Location of Death Bowle  | 4c. County of Death Prince George's   |
| Funeral  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthd.   |   | Date of Birth(MM/DD/YYYY) 9. Birthplace (State or   |
| Director   | 0107-58-0878 1×M 20F 41   | Yrs. Months Days Hours Min.   | May 24,1966 Foreign Country) New York   |
|  | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or  | Location  | 10d. Inside City Limits   |
| ow any   | 10a. State 10b. County 10c. City, Town or   | ,   | 1 ∑Yes 2 No   |
| Aaryland<br>28a-f show<br>1 at once.<br>ector  | 10e. Street and Number  | 10f. Zip Code   | 10g. Citizen of What Country?   |
| ith the Maryland<br>23a or 28a-f sho<br>notified at once.<br>al Director   | 13304 Meladie Tuco  | 20715   | U.S.A   |
| r death with or items 23 must be no Funeral  | Armod Forece?   | <ol> <li>Was Decedent of Hispanic Origin? (Specify<br/>If Yes, specify Cuban, Mexican, Puerto Rica</li> </ol> | ( Yes or No-<br>in, etc.) 14. Race - American Indian, Black,<br>White, etc.               |
| or death   | 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 VDivorced If Yes, Give Year  | 1 Yes 2 No specify:   | specify: PS/AK  |
| urs afte<br>tural"<br>amine  | 15 Decedent's Education (Specify only highest grade completed) 16a. De  | cedent's Usual Occupation (Give kind of work  |   |
| 6<br>72 ho<br>an "na<br>cal Ex   | Elementary/Secondary (0-12) College (1-4 or 5+)   | ring most of working life. DO NOT use retired)  | 14/10 1   |
| 5-0036 ed within 72 hour 14 yigiene. other than "natu the Medical Exan Completed   | 17. Father's Name (First, Middle, Last)   | 18. Mother's Name (Fir  | st, Middle, Maiden Surname)   |
| 21215-0036 uld be filed within 7 Mental Hygiene. e cerent, the Medical   | Kennoth 1 Neal  | Lelia   | Ann Connolly  |
|  | 19a. Informant's Name/Relationship (Type, Print) (mother) 19b.  | Mailing Address (Street and Number or Rura  | Route Number, City or Town, State, Zip Code) // 2/16                                      |
| MD and 2 sho salth and 27 is em 27 is raumat   | MCS Letia Hyn Queen 1/6<br>20a. Method of Disposition 20b. Place of   | Disposition (Name of cemetery, Day  | ate 20c. Location - City or Town, State   |
| Baltimore,<br>Permit. Pages I a<br>Department of He<br>Important: If ite   | 1 Burial 2 Cremation 3 Removal from State cremator  | y or other place) 5/17  | 2008 Anotherilla NY   |
| ortant   | 4 Donation 5 Other Specify: TM (U   | 22. Name and Address of Facility  | Alving the just   |
| Ba<br>Perm<br>Perm<br>Impu<br>inju   | Jaroph L-Kuss   | 2222 W. North Ave.  | neral Home, P.A.  |
| Physician<br>Medical   | 23a Part I. Enter tife disease, or complications that exused the death. Do not failure. List only one cause on each line.   | enter the mode of dying, such as cardiac or res   | spiratory arrest, shock, or heart Approximate Interval Between Onset and Death            |
| caminer  | Immediate Cause (Final disease or condition resulting in death)  Intracerebral hemorrhage  Due to (or as a consequence of): |   | 333   |
|  | Sequentially list conditions.   |   |   |
| iiner  | if any, leading to immediate Due to (or as a consequence of):   |   |   |
| ted<br>Insit<br>Examine  | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):                          |   |   |
| Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Completed by Physician/Medical Exi   | d. UNPENDED AMENDED   |   |   |
| 60,<br>ate be on the beat of the principal | IF FEMALE: 23c. If yes, outcome of pregnancy  |   | 23d. Date of delivery   |
| Ox 6876 sath certificat attending ph for use as the  | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death 5                             | Fetal death 3 Ectopic pregnancy   | Month Day Year  |
| Box 6876, he death certificate of the attending phy hed for use as the landysician/M   | 1 Yes 2 No 9 Unknown g Unknown  | Other (Specify)   |   |
| P.O. Be<br>that the de<br>med by the<br>detached fi<br>by Phy  | Part II. Other significant conditions contributing to death but not resulting   | in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  1 Yes 2 ✔ No 3 Probably 4 Unknown |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death.  al Director: After this certificate has been signed by led in by the finneral director, page 2 should be detach errification: To Be Completed by P  |   |   | 24a. Was an 24b. Were autopsy findings available  |
| (ecords, the law requires are has been signed 2 should be ompleted   |   |   | autopsy prior to completion of cause of death?  |
| Rec<br>: The<br>iffcate<br>r, page   | 25. Was case referred to medical  | 26.Place of Death (Check only   | 1 Yes 2 No 1 Yes 2 No vone)   |
| Vital ysician ysician directol   | evaminer?   | patient 3 DOA Other Nursing H   |   |
| of \ of After tl uneral  | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. T   |   | d. Describe how injury occurred   |
| Sion<br>Mtendi<br>death.<br>ctor:<br>cy the f  | 1 V Natural 5 Pending 2 Accident Investigation  | 1 Yes 2 No  | of, Location (Street and Number or Rural Route Number, City                               |
| Division o<br>spital or Attending<br>tours after death.<br>neral Director: Aft<br>filled in by the fune<br>Certification:  | Suicide 6 Could not be determined (Specify)   | m, street, factory, office building, etc. 28  | or Town, State)   |
| C File to Pai  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deal  | h occurred at the time, date and place, and du  | e to the cause(s) and manner as stated.   |
| Division of Vital Rec<br>To the Hospital or Attending Physician: The I<br>within 24 hours after death.<br>To the Funeral Director: After this certificate I<br>completely filled in by the funeral director, page<br>Medical Certification: To Be Corr   | one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.   | vestigation, in my opinion, death occurred at the   | ne time, date and place, and due to the cause(s)  |
| Ž  | 29b. Signature and title of certifier   | 29c. License number O.C.M.E.  | 29d. Date signed (Month, Day, Year) May 10, 2008  |
| <  | 30. Name and address of person who completed cause of death (Item 23a)  | 5.5.11.21   |   |
| (1)  | Margarita Korell MD. Assistant Medical Examiner   | 111 Penn Street, Baltimore, MD 21   | 201   |
| State  | 31. Date filed (Month, Day, Year) 7 2008 32. Higistran's Signature  | porte   |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 09:19 A M 25 Henr au: /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hopkins Baitimo HOSDITO None Year If Under Hours 8. Date of Birth (Month, Day, Year)
July 15,1942 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Min. Months 1**X** M 2 ☐ F Virginia 230 54 7717 65 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3726 Restmor Knoll 21042 United States Funeral within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. i **⊠Y**es 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: unknown 1 ☐ Yes 21 No þ Specify. Specify: 3 Widowed 4 Divorced White 'natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation the Medical 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than ury or other traumatic event, the Ment or other traumatic event or other or other traumatic event or other or other event or ot 12 **UPS** Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Owen Eugenia Overstreet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia L. Owen/Wife 3726 Restmor Knoll Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Crematory 5-27-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc 0M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final lacteremia **Physician** over I month resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Year Day 4 □ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the detached 9∏Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page, this certificate 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 No P 1 🗌 Yes 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After (Month, Day Year) 1X Natural 5 ☐ Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director; Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 🖄 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier obubhani voumon May

State

Registrar

31. Date filled (Month, Day, Year)

MAY 2

7 2008 street , Pathmore, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Hophal North Worfe

08-03867 Steve Puciato

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| eve i dolato   |                                       | For State  | or waryia                      |                                | ertificate of             | Death                                      |                      |                               | Reg                  | No.                          |                       |  |
|--|---------------------------------------|--|--------------------------------|--------------------------------|---------------------------|--|----------------------|-------------------------------|----------------------|------------------------------|-----------------------|--|
| Physician/   |                                       | Decedent's Name (First, Middle,La  |                                |                                |                           |  |                      | Mo                            | ate of Death<br>onth | Day Year                     |                       | Time of Death<br>1935 hrs              |
| edical Examine   |                                       | Steven George  |                                | 9                              |                           |  | ,                    |                               | ay 20, 200           | 4c. County of                |                       |  |
|  | 4                                     | a. Facility Name (if not institution, g  | ive street and nur             | mber)                          | 1                         | 4b. City, Town, or I<br>Baltimore          | _ocation of I        | Death                         |                      |                              |                       |  |
|  | Ļ                                     | 2150 Harman Avenue   |                                | 7. A = a. /lm + cm             | lost hirthday)            | If Under 1 Year                            | If Under             | 24Hrs. 8.1                    | Date of Birth        | (MM/DD/YYYY)                 |                       | ace (State or                          |
| Funeral<br>Director  |                                       | 217-74-5535  | Sex<br>M 2 F                   | 7. Age (in yrs                 | s. last birthday) Yrs     | Months Days                                | _                    | 1.0                           |                      |                              | Foreign<br>Countr     | y) MD                                  |
| <b>&gt;</b> :  | _                                     | sual Residence of Decedent  0a. State 10b. County  |                                | 10c. Ci                        | ity, Town or Locat        | tion                                       |                      |                               |                      |                              | 10                    | d. Inside City Limits                  |
| w an   | 1                                     | MD N/A   |                                |                                | •                         | Baltimor                                   | e                    |                               |                      |                              | 1                     | Yes 2 No                               |
| Aaryland 28a-f show i at once.   | <u> </u>                              | 0e. Street and Number  |                                |                                |                           | 10f, Zip Code                              |                      |                               | 100                  | g. Citizen of Wha            | at Country            | ?                                      |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland leath and Menal Hygiers, et em 27 is marked other than "matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once To Be Commissed by Firmeral Director  | ֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | 2150 Harman Ave  | enue                           |                                |                           | 2  | 1230                 |                               |                      | United                       | l Sta                 | tes                                    |
| with 1   |                                       | 1. Marital Status  |                                | cedent Ever in                 | 13. W                     | as Decedent of His<br>Yes, specify Cuban   | panic Origin         | n? ( Specify<br>Puerto Rica   | Yes or No-           | 14. Race -<br>White          |                       | n Indian, Black,                       |
| r death with or items 23 must be no  |                                       | Never Married 2 Marri  | ed Armed Fo                    | 2 No                           |                           |  |                      |                               | ,                    |                              |                       |  |
| ral", o  |                                       | 3 Widowed 4 X Divorce  | ed If Yes, Give Yes            | 1972-19                        | 996 1                     | Yes 2X No                                  |                      | - 4 - 5                       | dama I               | Specify:<br>16b, Kind of Bus |                       |  |
| 72 hours<br>n "natur<br>al Exami   | įΓ                                    | 15. Decedent's Education (Specify  |                                |                                | ) 16a. Decede<br>during r | nt's Usual Occupat<br>most of working life | DO NOT u             | ind of work (<br>ise retired) | done                 | CCJM                         |                       | usuy                                   |
| on 72 h  |                                       | Elementary/Secondary (0-12)  11  | College (1                     | 1-4 or 5+)                     | Sur                       | rveyor                                     |                      |                               |                      | Compa                        |                       |  |
| .0036<br>Lwithin 72<br>giene<br>her than<br>te Medical   |                                       | 7. Father's Name (First, Middle, La  | net)                           |                                |                           |  | 18.Mother's          | Name (Fire                    | st, Middle, M        | aiden Surname)               |                       |  |
| 215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica   | וי                                    | John Paul Puci   |                                |                                |                           |  |                      | Ber                           | tha Fr               | eisheim                      | 1                     |  |
| D 21215-003 should be filed within and Mental Hygiene. 7 is marked other thatic event, the Med To Bo Comm  | oΓ                                    | 19a. Informant's Name/Relationship   |                                |                                |                           | ng Address (Stree                          | et and Numb          | per or Rural                  | Route Num            | ber, City or Town            | ı, State, Z           | ip Code)                               |
| MD 2 should 2 should but and 1 is m 27 is raumatic   | 1                                     | April C. Drisc   | oll <b>-</b> Da                |                                |                           | South Ro                                   |                      |                               |                      | imore,                       | MD 2                  | 1224                                   |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hou Department of Health and Mental Hygiene. Important: If iten 27 is marked other than "nat injury or other traumatic event, the Medical Exa   | Ţ                                     | 20a. Method of Disposition   |                                | 20                             | b. Place of Dispo         | osition (Name of ce                        | metery,              | Da                            | ate                  | 20c. Location -              | City or To            | own, State                             |
| Baltimore, permit. Pages I at Department of He Important: If ite injury or other tr  | 1                                     | 20a. Method of Disposition    X   Burial   2   Cremation                                     | 3 Removal f                    | rom State [V                   | movetera                  | an Cemete                                  | ry e                 | 5 <b>-27-</b>                 | 2008                 | Crowns                       | vill                  | e, MD                                  |
| Itin Partme ortan  |                                       | 4 Donation 5 Other Spec<br>21. Signature of Funeral Service Li                               | censee                         |                                |                           | Name and Addres                            |                      |                               |                      |                              |                       |  |
| Balt<br>permit.<br>Depart<br>Impor<br>injury   | Л                                     | A DANTINE  | TICLU                          | LAL                            |                           | 1328 Sulp                                  |                      |                               |                      |                              |                       |  |
| Physician  | 1                                     | 23a. Part I. Enter the disease, or confailure. List only one cause or                        | each line                      | caused the de                  | eath. Do not enter        | the mode of dying                          | , such as ca         | ardiac or res                 | spiratory arre       | est, shock, or hea           | art                   | Approximate Interval Between Onset and |
| Medical  |                                       | Immediate Cause (Final disease   | a. Complicati                  | ions of chr                    | ronic alcoholis           | sm   |                      |                               |                      |                              |                       | Death                                  |
| caminer  | ١                                     | or condition resulting in death)   | Due to (or as                  | a consequen                    | ce of):                   |  |                      |                               |                      |                              |                       |  |
|  | _                                     | Sequentially list conditions,  | b<br>Due to (or as             | a consequen                    | ce of).                   |  |                      |                               |                      |                              |                       |  |
|  |                                       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated | C.                             | a oonooqaa                     |                           |  |                      |                               |                      |                              |                       |  |
| , ji   | Examine                               | events resulting in death) Last  | Due to (or as                  | a consequen                    | ce of):                   |  |                      |                               |                      |                              | ļ                     |  |
| recuted  |                                       |  | d                              |                                |                           |  |                      |                               |                      |                              |                       |  |
| 760,<br>cate be execut<br>physician and<br>he burial - tra   | Medical                               | UNPENDED   | AMENDED                        |                                |                           |  |                      |                               |                      | 23d. Date of                 | f delivery            |  |
| 3760<br>ificate b<br>ig physics<br>s the bu  |                                       | IF FEMALE:<br>23b. Was decedent pregnant in the  | 23c. If yes                    | , outcome of points            |                           | Fetal death 3                              | Ectopic              | c pregnancy                   | ,                    | Month                        |                       | ау Үеаг                                |
| Box 687<br>e death certific<br>the attending   | 힐                                     | past 12 months?  | 7                              | gnant at time o                |                           | Other (Specify)                            |                      |                               |                      | 1                            |                       | 0.5                                    |
| Bo e deat the at the at  | Physician                             | 1 Yes 2 No 9 Unkr  | aOUK                           | nown                           | de la de                  | - un derbine cours                         | given in Pa          | art I                         | 23e. Did to          | obacco use cont              | ribute to th          | ne cause of death?                     |
| P.O. Bost that the degree by the dedeatched for the desired by the desired for | 징                                     | Part II. Other significant condition   | ons contributing               | to death but i                 | not resulting in the      | e underlying cause                         | givenini             | art 1.                        |                      |                              |                       | ably 4 🗸 Unknown                       |
| ords, P.C. w requires that as been signed 1 should be deta   | g                                     |  |                                |                                |                           |  |                      |                               | 24a. Was             | an 24b.                      | Were aut              | opsy findings available                |
| aw req   | 흺                                     |  |                                |                                |                           |  |                      |                               | auto                 | osy<br>ormed?                | prior to co<br>death? | ompletion of cause of                  |
| Rec<br>The la  | Completed                             |  |                                |                                |                           |  |                      |                               |                      | 2 No '                       | 1 Yes                 | s 2 No                                 |
| tal Rec  | 8                                     | 25. Was case referred to medical examiner?   | Hospital:                      | 1                              |                           |  | oe of Death<br>Other | (Check onl                    |                      | Residence 6                  | ✓ Other:              | Scene                                  |
| Physic<br>rrthis   | ٥                                     | 1 ✔ Yes 2 No   | ·                              | Inpatient :                    | 2 ER/Outpatie             |  | jury at Worl         |                               |                      | how injury occur             |                       | - Courte                               |
| J Of<br>Jing Ph<br>After   | 6                                     | 27. Manner of Death 1 ✓ Natural 5 Pendi  | (Mor                           | te of Injury<br>ath, Day,Year) | 200. 11110                |  | Yes 2                |                               |                      |                              |                       |  |
| SiOI<br>Attended<br>death<br>death<br>sy the   | ati                                   | o i dildi  | instian                        | ace of Injury -                | At home, farm, s          | treet, factory, office                     | building, e          | tc. 28                        | 8f. Location         | Street and Num               | ber or Rur            | ral Route Number, City                 |
| Division of Vital Records, tal or Attending Physician: The law require is after death.  The birector: After this certificate has been sized in by the funeral director, page 2 should be in by the funeral director, page 2 should be in the funeral director.   | Certification:                        | deterr   | not be                         |                                | , a nome, and             | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,    |                      |                               | or Town,             | State)                       |                       |  |
| hou fill   |                                       | 4 Homicide 29a. Certifier 1 Certifying Ph  | veicion: To the h              | est of my kno                  | owledge, death oc         | curred at the time,                        | date and pl          | ace, and du                   | ue to the cau        | se(s) and mann               | er as state           | ed.                                    |
| the H<br>thin 2-   | Medical                               | one) 2 ✓ Medical Exam  | niner:On the basi<br>and manne | s of examinat                  | tion and/or investi       | igation, in my opini                       | on, death o          | ccurred at ti                 | he time, date        | and place, and               | due to the            | e cause(s)                             |
| T William  | Me                                    | 29b. Signature and title of certifier  |                                | stated.                        |                           |  | nse number           | r                             |                      | 29d. Date sig                | ned (Mor              | nth, Day, Year)                        |
|  |                                       | Join & S   | 1                              | np                             |                           | 0.0  | C.M.E.               |                               |                      | May 21, 2                    | :008                  |  |
| 9  |                                       | 30. Name and address of person   | +                              |                                | (Item 23a)                |  |                      |                               |                      |                              |                       |  |
| 5+1  |                                       | Tasha Greenberg MD.  | Assistant                      | Medical E                      | xaminer 1                 | 11 Penn Stree                              | t, Baltimo           | ore, MD                       | 21201                |                              |                       |  |
| Sta<br>Registi   |                                       | 31. Date filed (Month, Day, Year)  | 2008                           | Registrar's S                  |                           | Sert                                       |                      |                               |                      |                              |                       |  |
| DHMH 17 Rev 1/20   |                                       | OCME   |                                |                                | ORIGII                    |  |                      |                               |                      |                              |                       |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|            |   | -                | For State of Maryland /  <br>1 - State Registrar  |   | ificate of E                                  |   |                                   | Reg. No.         | 2000                             | 17            | 106               |
|------------|---|------------------|---|---|---|---|-----------------------------------|------------------|----------------------------------|---------------|-------------------|
|            | 34.5.1  |                  | 1. Decedent's Name (First, Middle, Last)  |   |   |   | 2. Date of De<br>Month            | ath Day          | / Year                           | 3. Time       | of Death          |
| # 1        | Physicia<br>/Medic  |                  |   | 001                                     |   |   | may                               | 27               | 2_ 2008<br>County of Death       | 23            | - TOPM            |
|            | Examin  | er               | 4a. Facility Name (If not institution, give street and number)  | Tick                                    | 4b. City, Town, or                            |   | 2=                                | 46.              | County of Death                  |               |                   |
| 3          | *.  |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last b.  | irthday)                                | If Under 1 Year                               | If Under 24 Hrs.                          | 8. Date of Bir<br>(Month, Da      | th<br>Vear       | 9. Birth                         | place (State  | or Foreign        |
| В          | Funeral<br>Director   |                  | 212–46–6964 1□XM 2□ F 62  | Yrs.                                    | Months Days                                   | Hours Min.                                | 11/14/                            | 1945             |                                  | yland         |                   |
|            | pu: N   |                  | Usual Residence of Decedent  10a, State 10b, County 10c, City, Tow  | wn or Loca                              | ation   |   |                                   |                  |                                  | 10d. Inside   | City Limits       |
|            | f shoved at   | o                |   | 11-                                     |   |   |                                   |                  |                                  | 1             | s 2 <b>∐X</b> √lo |
|            | r 28a-  | irect            | Maryland Baltimore Dundal  10e. Street and Number   | TV.                                     | 10f. Zip Code                                 |   |                                   | 10g. Cit         | izen of What Cou                 | ntry?         |                   |
|            | th with<br>23a ol<br>ist be   | al D             | 1631 Searles Road   |   | 21222   |   |                                   |                  | S. A.                            |               |                   |
|            | tems<br>tems  | Funeral Director | 11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?   | 13. W                                   | as Decedent of His<br>Yes, specify Cuba       | spanic Origin? (Spo<br>n, Mexican, Puerto | ecify Yes or No<br>Rican, etc.)   | )-               | 14. Race - Ameri<br>Black, White |               |                   |
| 36         | be filed within 72 hours after death with the Maryland that Hyglene.  do other than "natural", or items 23a or 28a-f show od other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by F             | 1 □ Never Married 2 🛣 Married 1 □ X es 2 □ No 1963<br>3 □ Widowed 4 □ Divorced Year or Dates: 1975  | 1                                       | □Yes 2□XNo                                    | Specify:                                  |                                   |                  | Specify: Wh                      | ite           |                   |
| 21215-0036 | 2 hou<br>latura<br>ical E   |                  |   | ia. Decede                              | ent's Usual Occupa                            | ation<br>during most of work              | ina                               | 16b. K           | ind of Business/Ir               | ndustry       |                   |
| 215        | within 7<br>iene.<br>than "n<br>the Medi  | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)  |   |   | furing most of work<br>)                  |                                   |                  | mmercial<br>uipment              | . Cook        | ing               |
| 121        | iled w<br>Hygier<br>ther th   |                  | 12 As   | ssemb                                   | oter  | 18. Mother's Name                         | e (First, Middle                  |                  |                                  |               |                   |
| anc        | lld be fi<br>lental H<br>ked ot<br>ic evel  | o Be             | Hugh Poole, Sr.   |   |   | Catheri                                   | ne Jest                           | er               |                                  |               |                   |
| Maryland   | shou<br>nd M<br>mar   | ၉                |   | 9b. Mailing                             | Address (Street a                             | and Number or Rur                         | al Route Numb                     | er, City         | or Town, State, Zi               | ip Code)      |                   |
|            | and 2<br>ealth a<br>n 27 is   |                  | Karma Jean Poole (Wife)   | 1631                                    | Searles                                       |   | ndalk,                            |                  | land 212                         |               |                   |
| ore        | 0 0   |                  | 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State   | of Dispos<br>tery, crem                 | ition (Name of<br>latory or other plac        | 1 3/1                                     | 27                                |                  | ocation - City or T              |               | -                 |
| altimore,  | t. Pag<br>rtmen<br>rtant;<br>rjury  |                  | 4 □ Donation 5 □ Other (Specify) Oak ]  |   | Cemetery                                      |   |                                   |                  | timore,                          | Maryl         | and               |
| Bal        | permit. Page<br>Department of Important; If any injury or once.   |                  | 21. Signature of Funeral Service Licensee   | 114                                     | 407 Old F                                     | ss of Facility<br>Li Funera<br>Castern A  | venue                             | Esse             | x, Mary]                         | land 2        | 1221              |
|            | · · · · · · · · · · · · · · · · · · ·   |                  | 23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  | o not ente                              | er the mode of dyin                           | g, such as cardiac                        | or respiratory                    | arrest,          |                                  | Approxin      | nate<br>Between   |
|            | Physician   | 0 0              | Immediate Cause (Final disease or condition resulting in death)   | ESS                                     | FLECTI  | RIEMAN A                                  | CTIVIT                            | 4                |                                  | Onset ar      | Min_              |
| 4          | /Medical  |                  | Due to (or as a consequence   | ce of):                                 |   |   |                                   |                  |                                  | / 1           | 10                |
|            | Examiner  | ē                |   |   | EMIA  |   |                                   |                  |                                  | 6.1           | tours             |
| J.         | nted<br>Insit   | mine             | cause. Enter Underlying   | ,                                       | VUS   |   |                                   |                  |                                  | 181           | tours             |
| )<br>O     | exect<br>an and<br>rial-tra   | Examin           |   |   |   |   |                                   |                  |                                  | 1.0-1         | buse              |
| 68760,     | law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit  | edical           | d. CVA  |   |   |   |                                   |                  |                                  | 47 1          | ours              |
|            | certific<br>ding p  | /Mec             | IF FEMALE: 23c. If yes, outcome pf pregnancy  |   |   |   |                                   |                  | 23d. Date of deli                | ivery         |                   |
| Box        | death certifi<br>attending<br>of for use as   | Physician/M      | in the past 12 months?    Continue of death   Continue of death | ath 3□                                  | Ectopic pregnancy<br>  Other <i>(specify)</i> | /   |                                   |                  | Month                            | Day           | Year              |
| P.O.       | that the de<br>led by the a   | hysi             | 9 Unknown   |   |   |   |                                   |                  |                                  | Manager 1     | - 6               |
|            | ires tha<br>signed I<br>be det  | by P             | Part II. Other significant conditions contributing to death but not resulting   | g in the ur                             | iderlying cause giv                           | en in Part I.                             |                                   | tobacco<br>Yes 2 | use contribute to                |               | □Unknown          |
| Records,   | w requir<br>been si<br>should   | sted             |   |   |   |   | 24a. Wa                           |                  | 24b. Were au                     |               |                   |
| Rec        | The law<br>ate has b  | Completed        |   |   |   |   | aut<br>per                        | opsy<br>formed?  | prior to death?                  | completion of | of cause of       |
|            |   |                  | 25. Was case referred to medical  |   |   | 26. Place of Dea                          | 1  Yes<br>th (Check onl           | -                | lo 1∐Yes                         | 2□ No         |                   |
| or Vital   | di s  | To Be            | examiner?   | Outpatien                               | t 3 DOA Oth                                   | ner:<br>4 ☐ Nursing H                     | ome 5□Re                          | sidence          | 6 □Other (Spe                    | cify)         |                   |
| n o        | ng Ph<br>(fter thi  |                  | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28a. Date of Injury (Month, Day Year)   | b. Time of<br>Injury                    | Wor   |   | 28d. Describe                     | e how inj        | ury occurred                     |               |                   |
| sio        | Attending r death. ector: After by the fune   | cati             | 2 Accident investigation 3 Suicide 6 Could not be   | . farm. str                             |   | Yes 2 □ No                                | 28f. Location                     | (Street a        | and Number or Ri                 | ıral Route İ  | lumber,           |
| Division   | after of Direct of Jin by   | Certification:   | 4 Homicide determined building, etc. (Specify)  | , | ,   |   | City or T                         | òwn, Sta         | te)                              |               |                   |
|            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | alc              | 29a. Certifier   1   Certifying Physician: To the best of my knowled (Check only   2   Medical Examiner: On the basis of examination  | dge, deat                               | h occurred at the ti                          | ime, date and place                       | e, and due to thurred at the time | e cause          | (s) and manner as                | s stated.     | se(s)             |
|            | the Hin 24<br>the Fi  | Medical          | one) and manner stated.   |   | 29c. Licens                                   |   |                                   |                  | Date signed (Mont                |               |                   |
|            | With Con  | 2                |   | or TINE                                 |   |   |                                   |                  |                                  |               |                   |
|            | - 1-1   |                  | 30. Name and address of person who completed cause of death (Item 23  | Ba) (Type                               | Print)  | - 00                                      |                                   | 7 0              | JM 23                            | 1200          | 0                 |
|            | 1011  |                  | CURISTOMER S. HOURIGH 4940  | EAS                                     | TENN A  | 25 - 000<br>VENUE                         | BAL                               | Too              | vane,                            | nD 2          | 1224              |
| ۳          |   | ate              | 31. Date filed (Month, Day, Year), 2008 32. registrar's Signature   |   | N.  |   |                                   |                  |                                  |               |                   |
|            | Regist  | rar              | THE IS I SHOW THE SAME TO   | 143                                     | AND THE PARTY                                 |   |                                   |                  |                                  |               |                   |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** PHILLIPS 1:41 MA 2008 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner UTY BAYVIEW MEDICAL CENTER BALTIMORE JEHNS HOIKINS If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Year) Days Hours 1 ☑ M 2 □ F 251 38 9512 Director Dec. 10, 1928 South Carolina Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits at 1 ☐ Yes 2 ☑ No Examiner must be notified Director Maryland Baltimore Sparrows Point 28a-f 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 9105 Avenue B 21219 USA 23a death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. e filed within 72 hours after all Hygiene. 1 XYes 2 No If Yes, Give Korean Year or Date War 1 ☐ Never Married 2 → Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify: Ş Q 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Law Enforcement Baltimore City 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental I if Health and Menta Item 27 is marked Benjamin Franklin Phillips Cora Love 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri Shirley Phillips (Wife) 9105 Avenue B Baltimore, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If Ite any injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Inc. 5/27/2008 Baltimore, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facilit Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, Mar 1407 Old Fastern Avenue Maryland 21221 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hypoxic (ESP) disease or condition resulting in death) /Medical Examiner 48 hours Sequentially list conditions Examine ii any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending p for use as as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, à 3 MiProbably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient Certification: To 2 ER/Outpatient 3□ D0A 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) Injury Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MEDICAL DOCTOR of death (Item 23a) (Type, Print) BAUTIMORE, MARYLAND medual center State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death U Day **Physician** 2008 May 23 12:53 PM Harry Propalis, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Presbyterian Home of Maryland Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day) July 4, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 235-20-3364 85 Ohio Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Parkton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ō USA 18419 Foreston Road 21120 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: or items, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify þ 3 X Widowed 4 ☐ Divorced white "natural" Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) |Senior Illustrator Bendix Corp. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Propalis, Sr. Mary Papamichael 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Valle 18419 Foreston Road; Parkton, MD 21120 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation S☐ Other (Specify) Garrison Forest 5/30/08 Owings Mills, MD 21. Signature of Fineral Service/Licenses 22. Name and Address of Facility 1050 York Road eth Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line Immediate Cause (Final disease or condition resulting in death) Physician e real /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 5 ☐ Other (specify) the 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 ☐ Yes 3 Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death? ATRIAL FIBRILLATION 24a, Was an has e 2 autopsy performe certificate ha 1 ☐Yes 2 ☐ No 2 director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 ☐ Yes ၉ 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Natural 5 ☐ Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 2 Accident Director; / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Vithin 24 hours are To the Funeral Dir To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

State

6565 Norat CHARLES STREET

Sulte 33

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ow

32. Registrar's Signature

VALLE, JR

7 2008

31. Date filed (Month, Day, Year)

MAY 2

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND TIEM#14-perFH, 6902, 473072010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. ( 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month 2008 ar May 23. 5:31 A M Samuel Redd, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | FEB 28, 1933 9. Birthplace (State or Foreign Country) Mary Land Sex 1X M 2□ F Social Security Number 7. Age (In yrs. last birthday) **Funeral** 218-26-5417 75 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evan incermust be notified at once. 1 ☐Yes 2 No Director MD Baltimore Hanover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21076 USA 6015 Shady Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status ive 1953-Black, White, etc. 1 Never Married 2 Married Specify Black White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Thoroughbred Race Horse Trainer | Horse Training 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) Anna Hilliard Samuel Redd ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhonda Redd/Daughter 6015 Shady Lane Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State Metro Crematory,Inc 5/24/08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Cremation Society of Maryland, Inc. C. Todd Dring Tolk 299 Frederick Rd Baltimore, MD21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only recause on each line. Immediate Cause (Final gangrene **Physician** weeks disease or condition resulting in death) ) /Medical Due to (or as a consequence of): **Examiner** eripherar Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 4 Pregnant at time of death Month Day Ye ar 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cancel 1 Yes 2 No 3 Probably 4 Nown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 25 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) (Specify) \( \text{NO-Spice} \) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death

To the Funeral Director; \
completely filled in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier MAY 23 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charls ST TONSON MD ZIZOCI commes in AARON

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Begistrar's Signature

Salta de

### 08-03901 Ralph E. Reitan

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 21, 2008 2004 hrs **Medical Examiner** Ralph Erick Reitan 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** oreign Months Days Hours Min Director 192-38-8558 Country) 1 **X** M 2 F Yrs NOV 29 1948 59 Usual Residence of Decedent 10d. Inside City Limits à 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 X No s 23a or 28a-f show e notified at once. Anne Arundel Annapolis 4 contract of the second se death with the Maryland rector 10g. Citizen of What Country 10e. Street and Number 10f, Zip Code ö 1179 Hampton Road 21409 Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Examiner must be White, etc. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Mamied 2 X Married 2 X No Yes permit. Pages I and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or injury or other traumatic event, the Medical Examiner m If Yes, Give Yeer Yes 2 X No specify: Specify: White 4 Divorced 3 Widowed 2 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Information 21215-0036 **Technology** 4 Computer Scientist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ragnar Reitan Gundhild Walstad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) timore. MD Margaret J. Reitan - wife 1179 Hampton Road. Annapolis. MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Metro Crematory, Inc. 5/23/2008 Baltimore, MD Donation 5 Other Specify 22. Name and Address of Facility Cremation Society of 299 Frederick Road, 21. Signature of Funeral Service Licensee Williams of Maryland, d, Baltimore, 21228 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a. Drowning Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed and Physician/Medical AMENDED UNPENDED the attending physician led for use as the burial The law requires that the death certificate be Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 5 į 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed ficate has been s , page 2 should t 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed' death? ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Division of Vital Be examiner? Other Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA After this ٩ 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Subject drowned May 21, 2008 1 1909 hrs Natural Yes 2 🗸 No Pending 24 hours after death. To the Funeral Director: 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) Chesapeake Bay, , Md determined (Specify) Bay 4 Homicide 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number May 22, 2008 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Ling Li, MD 31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature State

Registra

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

Be

**Funeral** 

Director

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at

Health and Mental Hygid Iem 27 is marked other

. Pages 1 and 2 should be file freent of Health and Mental H-tant: If Item 27 is marked oth Jury or other traumatic event

Department or Important: If I any Injury or

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Medical Certification: To Be Completed by Physician/Medical Examiner attending physician and for use as the burial-transi been signed by the should be detached within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Division or Vital Records, P.O. Box 68760

To the Hospital or Attending Physician:

| 23a. Part1. Enter the disease, or complication shock, or heart failure. List only on | fations that caused the death. Do not enter the mode of dying, such as cardiac or<br>e cause on each line. | respiratory arrest,                          | Approximate Interval Between Onset and Death |
|--|--|--|--|
| Immediate Cause (Final disease or condition  | MULTILOBAR PNUEMON   | 4  | Onset and Death                              |
| resulting in death)  | Due to (or as a consequence of):   |  |  |
|  | ACUTE RENAL FAILUR   | 三  |  |
| Sequentially list conditions, if any, leading to immediate                           | Due to (or as a consequence of):   |  |  |
| cause. Enter Underlying Cause (Disease or injury that initiated events               | ARTERIOSCLEROTIC MEAR  | J D156                                       | 755  |
| resulting in death) Last   | Due to (or as a consequence of):   |  |  |
|  |  |  |  |
|  |  |  |  |
| IF FEMALE: 23b. Was decedent pregnant  | 3c. If yes, outcome pf pregnancy   |  | 23d. Date of delivery                        |
| in the past 12 months?<br>1 □ Yes 2 □ No   | 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)     |  | Month Day Year                               |
| 9 □ Unknown  | 9□Unknown  |  |  |
| Part II. Other significant conditions con  | tributing to death but not resulting in the underlying cause given in Part I.                              | 23e. Did tobacco                             | use contribute to the cause of death?        |
| - ANEMIA   |  | 1 ☐ Yes 2                                    | Probably 4 Unknow                            |
| - HYPERTE  | NITION   | 24a. Was an                                  | 24b. Were autopsy findings availab           |
|  |  | autopsy performed?                           | prior to completion of cause of death?       |
| 25. Was case referred to medical   | OBSTRUCTIVE 24N4 DISEASE   |  | o 1 ☐ Yes 2 ☐ No                             |
| examiner?  | 26. Place of Death (   |  |  |
|  | ospital: 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 □ Nursing Hom                                      | e 5 Residence                                | 6 □Other (Specify)                           |
| 27. Manner of Death 1 2 Natural 5 □ Pending  | (Month, Day Year) Injury Work?   | d. Describe how inju                         | iry occurred                                 |
| 2 ☐ Accident Investigation   | M 1 ☐ Yes 2 ☐ No   |  |  |
| 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined                                 | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)                     | If. Location (Street a<br>City or Town, Stat | nd Number or Rural Route Number,<br>e)       |
|  |  |  |  |
|  | ician: To the best of my knowledge, death occurred at the time, date and place, ar                         |  |  |
| one)   | and manner stated.   |  |  |

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State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SUDICIR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATEZ.

32. Redistrar's Signature

MD

2000 W

29c. License number

D 23300

BON SECOURS POSP.

29d. Date signed (Month, Day, Year)

MAY

13ALTO. ST. BALTOMD, 21223

Featmend #21 Per FH State of Maryland / Department of Health and Mental Hygiene State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26) **Physician** 2008 6:00 p M MAY Diana Rush /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner 2933 Louisianna Avenue Baltimore **Baltimore** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday **Funeral** Months Days Hours Min 1 □ M 2 X F 53 MAY 4 1955 Maryland Director 215-64-3629 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 2933 Louisianna Avenue 21227 USA Completed by Funeral filed within 72 hours after death Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M2No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hygien Important: If item 27 is marked other the any injury or other traumatic event, If an Once. Licensed Practical Nurse Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marion Rush Delcie Hall Tee Ann ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Teresa Pross - sister 3020 Ohio Avenue, Halethorpe, 21227 MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/28/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee H. Williams 86 <sup>22</sup>Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac respirator Immediate Cause (Final disease or condition resulting in death) **Physician** 20 N /Medical (or as a consequence Examiner Sequentially list conditions, if any, reading to intribute cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Box 68760, ~ the Hospital or Attending Physician: The law requires that the death certificate be execu resulting in death) Last to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe Yes 2 1 □Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 Other (Specify) Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier Time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R 6 \$2. Registrar's Signature 31. Date filed (Month, Day, Year) State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Registrar

DHMH 17 Rev 1/2001

| 08-03833   |
|------------|
| Lula Russo |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| _ula | Russo   |                | S1<br>1- For State<br>Registrar  | ate of Maryla                                      |                         | artment of rtificate of              |                        | and          | Menta        | al Hyg    |                     | g. No.                | 008                     | 1701                           |
|------|---|----------------|--|--|-------------------------|--------------------------------------|------------------------|--------------|--------------|-----------|---------------------|-----------------------|-------------------------|--------------------------------|
|      | Physicia  | ın/            | Decedent's Name (First, Midd   | le,Last)   |                         |                                      |                        |              |              |           | . Date of Deat      | h                     |                         | me of Death                    |
| Mec  | dical Exami   | ner            | LULA RUSSO   |  |                         |                                      |                        |              |              |           | Month<br>May 19, 20 |                       | 10                      | 815 hrs                        |
| 1    |   |                | 4a. Facility Name (if not institution St Agnes Hospital  | on, give street and nu                             | ımber)                  | 4                                    | b. City, To<br>Baltimo |              | ocation of   | Death     |                     | 4c. County of         | Death                   |                                |
|      | Funeral   |                | 5. Social Security Number  | 6. Sex   | 7. Age (In yrs. I       | ast birthday)                        | If Under               |              | If Under     | _         | 8. Date of Birt     | h(MM/DD/YYYY)         | 9. Birthplac<br>Foreign | ce (State or                   |
|      | Director  |                | 217.16.5143  | 1 M 2 XXF  | 8                       | 39 Yrs.                              | Months                 | Days         | Hours        | Min.      | SEP 17,             | 1918                  | Country)                | MD                             |
|      | , h   | 1              | Usual Residence of Decedent  |  | Lie en                  |                                      |                        |              |              |           |                     |                       | 1401                    |                                |
|      | w an  | İ              | 10a. State 10b. County   |  | 10c. City               | Town or Location                     |                        |              |              |           |                     |                       |                         | Inside City Limits  (XYes 2 No |
| 1    | Maryland<br>28a-f show any<br>Latonce,  | ģ              | MD<br>10e. Street and Number   |  |                         | DALI                                 | 1MORE                  | 'ada         |              |           | 110                 | g. Citizen of Wh      |                         | A les 2                        |
|      | e Mar<br>or 28s   | Director       | 236 S. LOUDON AVE  |  |                         |                                      | TOI, ZIP C             | 2122         | a            |           | "                   | USA                   | at Country:             |                                |
|      | vith th<br>s 23a<br>s noti  | la l           | 11. Marital Status   |  | cedent Ever in U        | S 13 Was                             | Decedent               |              |              | 12 / Sne  | cify Yes or No-     |                       | - American Ir           | ndian Black                    |
| Y    | eath v<br>item  | uneral         | 1 Never Married 2 N  | arried Armed F                                     |                         |                                      | s, specify             |              |              |           |                     | White                 |                         | Total ( Didding                |
| 0    | ifter d   | ш.             | 3 XX Widowed 4 Div   | /orced If Yes, Give Yes                            |                         | 1                                    | Yes 2                  | X No         | specify:     |           |                     | Specify:              | WHITE                   |                                |
|      | ours s<br>atura   | d by           | 15. Decedent's Education (Spe  | cify only highest gra                              | de completed)           | 16a. Decedent                        | 's Usual O             |              |              |           |                     | 16b. Kind of Bus      | siness/Indust           | try                            |
|      | 6<br>n 72 h<br>an "n<br>ical E  | lete           | Elementary/Secondary (0-12)  | College (  | 1-4 or 5+)              | during me                            | St Of WORK             | ng me. L     | O NOT U      | se retire | u)                  |                       |                         |                                |
|      | withingiene   | Completed      | 10<br>17. Father's Name (First, Middle   | Local)   |                         | SWITCH                               | IBOARD                 |              |              | Nama (    | Ciant Mandalla M    | CAR DEALE             |                         |                                |
|      | 21215-0036 uld be filed within 77 Mental Hygiene. marked other than c event, the Medical  | Be C           | THOMAS FOSTER  | , Last)  |                         |                                      |                        | "            |              |           | HIPLEY              | nalderi Sumame)       |                         | ļ                              |
|      | MD 21215-0036<br>d 2 should be filed within 7<br>tth and Mental Hygiene.<br>n 27 is marked other than<br>wmaire event, the Medica   | TO B           | 19a. Informant's Name/Relations  | ship (Type, Print )                                |                         | 19b. Mailing                         | Address                | (Street      |              |           |                     | ber, City or Town     | n, State, Zip           | Code)                          |
|      | MD 12 sho<br>th and<br>27 is  |                | FRANKLIN F. RUSSO  | , JR.  | SON                     | 236 S.                               | LOUDON                 | N AVE        | ., BAL       | TIMO      | RE, MD              | 21229                 |                         | ) 1                            |
|      |   |                | 20a. Method of Disposition  1 Burial 2 X Cremation   | n 3 Domavel fr                                     |                         | Place of Disposi<br>crematory or oth |                        | of ceme      | etery,       |           | Date                | 20c. Location -       | City or Town            | n, State                       |
|      | Pages<br>Pages<br>nent of   |                | 4 Donation 5 Other S   |  | Oil State               | OOWR)IDGE N                          | . ,                    | AL GA        | RDEN\$       | MAY       | 23,2008             | ELKRIDGE              | E, MD                   |                                |
|      | Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite  |                | 21. Ign tuil of Funite Survice   | ense   |                         | FIN                                  | ame and A<br>IK FUNE   | ddress d     | of Facility  | РΔ        |                     |                       |                         |                                |
|      |   |                | 23a. Part I. Enter the disease of  |  | MOT                     | 426                                  | CRAIN                  | HWY          | . S.         | GLEN      | BURNIE.             | MD 21                 | 1061                    | proximate Interval             |
|      | Physician<br>/Medical<br><sup>©</sup> xaminer   | : 10           | failure. List only or eaulee<br>Immediate Cause (Final disease<br>or condition resulting in death) | on each line.<br>a. <b>Hypert</b> a                |                         | rdiovascu                            |                        |              |              |           |                     |                       | Be                      | etween Onset and<br>Death      |
|      |   | ē              | Sequentially list conditions, if any, leading to immediate   |  | a consequence o         | of):                                 |                        |              |              |           |                     |                       |                         |                                |
|      |   | Examiner       | (Disease or injury that initiated  | С  | a consequence o         | of):                                 |                        |              |              |           |                     |                       |                         |                                |
|      | uted<br>nd<br>ransit  | Ä              | events resulting in death) Last  | d.   | 2 00,1004001100 0       | .,,                                  |                        |              |              |           |                     |                       |                         |                                |
|      | 0,<br>be executed<br>sician and<br>burial - transit   | edical         | UNPENDED   |  |                         | er DVR, 26<br>ME,g880 6              | 719708                 | Æ,g8<br>3 11 | 80 6/3       | 30/08     | TT                  |                       |                         |                                |
|      | Box 68760<br>e death certificate b<br>the attending physical<br>for use as the bu   | siciar         | IF FEMALE: 23b. Was decedent pregnant in t past 12 months?  1 Yes 2 No 9 Un                        | he 1 Live t  | nant at time of de      | 2 Fet                                | aldeath<br>er (Specif  | з [<br>y)    | Ectopic      | oregnan   | су                  | 23d. Date of<br>Month | delivery<br>Day         | Year                           |
|      | Division of Vital Records, P.O. But all or Attending Physician: The law requires that the desirate death.  "I Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached for   | by Phy         | Part II. Other significant condi   | tions contributing t                               | o death but not r       | esulting in the u                    | nderlying o            | ause giv     | en in Pari   | ı.        |                     | bacco use contri      |                         | _                              |
|      | ds,<br>equire<br>een sig  | Completed      |  | <del></del>  |                         |                                      |                        |              |              |           | 24a. Was            | an 24b. V             | Vere autops             | y findings available           |
|      | n of Vital Records,<br>ling Physician: The law requit<br>After this certificate has been a<br>funeral director, page 2 should   | nple           | 1-1-1-1  |  |                         |                                      | ·                      |              |              |           | autop<br>perfoi     | rmed? d               | leath?                  | letion of cause of             |
|      | Re<br>The   |                | 05 Was assessed to asset to  |  |                         |                                      |                        | Diese        | of Death (0  | Dh I      | 1 ✓ Yes             | 2 No 1                | <b>✓</b> Yes            | 2 No                           |
|      | Vital Re<br>hysician: The<br>this certificate<br>I director, page   | Be             | 25. Was case referred to medica examiner?  | Ularated,  | Inpatient 2             | ER/Outpatient                        |                        | 10           | thor:        |           |                     | Residence 6           | Other:                  |                                |
|      | of V<br>ing Phy<br>After th   | 밁              | 1 ✓ Yes 2 No<br>27. Manner of Death  | 28a. Date  | of Injury               | 28b. Time of Ir                      |                        |              | at Work?     |           |                     | now injury occurr     |                         |                                |
|      | endin<br>ath.   | tio            | 1 Natural 5 Pen  | ding A   | n, Day, Year)<br>262008 | unk                                  | ŀ                      | 1 Ye         | s 2 X        | t ov      | fall                |                       |                         |                                |
|      | Visi<br>or Att<br>fter de<br>Direct<br>in by  | ifica          |  | stigation 28e. Place                               | ,                       | ome, farm, stree                     | t, factory, o          | office bui   | ilding, etc. |           |                     |                       | er or Rural R           | oute Number, City              |
|      | Di<br>pital<br>ours a<br>neral I  | Certification: | 4 Homicide dete  | rmined (Specify)                                   | re                      | esidence                             |                        |              |              |           | 236 S. La           | oudon Ave.            | Baltim                  | ore,MD                         |
| (J   | Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the atternompletely filled in by the funeral director, page 2 should be detached for u | edical         |  | hysician: To the beaminer:On the basis and manners | of examination a        |                                      |                        |              |              |           |                     |                       |                         | use(s)                         |
|      | . >   | ž              | 29b. Signature and title of certifi-   |  | 0                       |                                      |                        | License      |              |           |                     | 29d. Date signe       |                         | Day, Year)                     |
| 4    |   |                | Carde  | Hall   | Van                     |                                      |                        | O.C.M        | l.E.         |           |                     | May 20, 20            | 08                      |                                |
|      |   |                | 30. Name and address of person   | •  |                         | 123a)<br>111 Penn S                  | treat P                | altimo       | ra MD        | 21204     |                     |                       |                         |                                |
|      |   | ate            | Carol Allan, MD As   | sistant Medical                                    | egistrar's Signa        |                                      | aleet, B               | aillillo     | e, MD        | 2 1201    |                     |                       |                         |                                |
|      | Regis   | rar            | MAY27  | 2008   | ever D                  | 1984                                 |                        |              |              |           |                     |                       |                         | İ                              |

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** KIShei 9:08 A 2008 51 OD ET /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death County of Death **Examiner** LANDALL mouse MANO Moethwes) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 ☐ M 2 ☐ F Director 217-54-3560 February 24, 1951 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes Z☐ No Randallstown Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3608 Briarstone Road Funeral United State of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American I Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 Married 2 No 21215-0036 1 ☐ Yes 2XXVo Specify Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Social Security be filed within tal Hygiene. Elementary/Secondary (0-12) Coilege (1-4or 5+) Claims Examiner Administration 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be and Mental William James Rishel Ethel Lorene Wilkinson Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health of Important: If item 27 is any injury or other tra William & Ethel Rishel(Parents) 3719 Courtleigh Drive, Randallstown, Maryland 21133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 21228 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Metro Crematory Inc. 05/27/08 Catonsville, Maryland 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 21. Signature of Fugeral Service 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Er er ne disease, or complic tions th-shock, 'r he rt failure. List only on cause caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate cause/ Final disease or condit in resulting in Section Physician INA hossi /Medical as a consequence of) Examiner coholism Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit physician and resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical the attending for use as 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 5 ☐ Other (specify) 4☐Pregnant at time of death signed by the a d be detached f P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Syndrome 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has perfor this certificate 1∐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Certification: Injury at Work? (Month, Day Year) or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. the Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one and manner stated. ature ho completed cause of death (Item 24) (Type, Print) dress of person 401 82. Registrar's Signature Date filed (Month, Day, Year) 2008 7 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May Month **Physician** 2008 Louise Frances Stanton 22, 5:04 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2447 Deering Ave Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday, Funeral 1 □ M 2 💢 F **Director** 215-05-0495 88 Maryland DEC 3, 1919 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 10a. State 1 Yes 2 No Director MD N/A Baltimore 10e. Street and Number 2447 Deering Ave 10f. Zip Code 21230 10g. Citizen of What Country? ms 23a or 7 r must be n **USA** death Funeral 'natural", or Items dical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 Hygiene. College (1-4or 5+) Waitress Restaurant other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be h and Mental I Pages 1 and 2 should be Edward Hodges Grace Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Gary Stanton/Son 2447 Deering Ave Baltimore, MD 21230 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial 5/28/08 Elkridge, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee C. Todd Dring MacNabb Funeral Home, 301 Frederick Rd Catonsvil le, MD 21228 23a. Part1. Enter the disease, or conplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** End Stare Dementia yrs /Medical Due to (or as a consequence of) **Examiner** Gastroesophageal Reflux Disease Sequentially list conditions, if any, reading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last yrs Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760; Physician/Medical as IF FEMALE: for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 → Yo Day Month Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.0. 9☐ Unknown ate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, δ Constructures, anorexia 1 Yes 2 No 3 Probably 4 Hnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes No 1 🔲 Inpatient Certification: To 2 ER/Outpatient 3 DOA 5 Sesidence 6 □Other (Specify, After this 28c. Injury at Work? Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No after death.

Director: A
d in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Hospita 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 May 23, 2008

State Registrar

DHMH 17 Rev 1/2001

Allen Reilly,

Rolling Crossroads, Suite 307 Baltimore, MD 21228

30. Name and address of person who completed cause of leath (Item 23a) (Type, Print)

East

2008<sup>32. Registrar's Signature</sup>

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Veal **Physician** 5.10 PM Steven Salliey, Sr. MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE 6000 N/A HUSDITAL SAMARITAN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours **1**√ M 2 □ F 48 6/24/60 MD Director 220-78-0394 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at N/A MD 1 Yes 2 □ No Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 Harford Road 21218 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Yes 2√2 No If Yes, Give X Year or Dates: 1 ☑ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2√☐ No Specify: Allican American Specify Q Q 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event; the 10 once. Roofer the 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Abraham Salliev Bernice Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1226 E. Belvedere Ave, Balt., MD 21239 Carlyn Bright/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 5/21/08 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore, MD 22. Name and Address of Facility Hari P. Close F.Svs., PA 21. Signature of Funeral Jervice Li ensee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed HIV burial-tran the attending physician and Due to (or as a consequence of) Physician/Medical as the IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ FAILURE 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an PANCYTOPENI page 2 After this certificate 2 No 1□ Yes Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 [Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident death the f 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Division or Vital Records, P.O. Box 68760 within 24 hours after death To the Funeral Director: Hospital completely

> Registrar DHMH 17 Rev 1/2001

State

(Check only one)

29b. Signature and title of certifie

(000) 31. Date filed (Month, Day, Year) TENDING

PHYSICIAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

SAMACITATION 320 Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

MAW

00000339

NAING

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DANIEL 11:40 AM May 3008 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Hospital Landellstown Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10M 20F 217-26-8275 Usual Residence of Decedent 2 Yrs. Director with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits other then "natural", or Iteme 23a or 28a-f show vent, it a Medical Expiriting must be notified at 1 des 2 No Director 10f. Zip Code 10g. Citizen of What Country? 90 0 by Funeral Pages 1 and 2 should be filed within 72 hours efter deeth 12. Was Decedent Ever in U.S. Armed Forces?
1 Tes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race 11. Marital Status Black, White, etc. 2 No 1 Never Married 2 Married Specify: BIACK If Yes, Give Year or Dates: w W ゴ Baltimore, Maryland 21215-0036 2 No 3 Widowed 4 Drivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Secondary (0-12) College (1-4or 5+) Housing 17. Father's Name (First, Middle, Last) ie marked of 19a. Informant's Name/Relationship (Type, Pri 1) 19b. Mailing Address (Street and Number r Aural Route Number, City or Town, State, Zip Code) Department of Health ar Importent: If item 27 is eny Injury or other trai once. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 Cremation 3 □Removal from State 4 □ Denation 5 □ Other (Specify) 21. Sign of re of Funeral Service Licensee 23a. Part1. Enter the disease; or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac Immediate Cause (Final disease or condition resulting in death) **Physician** Atherosclevation Cardiovascular /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical signed by the attending d be deteched for use as IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certification; To Be Completed by 3 Probably 4 XUnknown 1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1□ Yes : After this certification, 25. Was case referred to medical examiner?
1 X Yes 2 ☐ No 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 X ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Naturai 5 Pending death. 1 ☐ Yes 2 ☐ No Director: / 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) within 24 hours efter of To the Funeral Direct completely filled in by 4 | Homicide 15 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H0055644 23, 2008

Registrar
DHMH 17 Rev 1/2001

State

MAY 2 7 2008

Old Courst

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Randallstown

MD

**Physician** William Shipley, JR. William May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Maryland Medical niversity of If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Aug 22, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1**X**M 2□ F Director 217-40-2174 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10h. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any Injury or other traumatic event, the Medical Examinar must be notified at **Funeral Director** Pasadena MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 1576 Wall Dr 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Was 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Be Completed by Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Maintenance 12 Coordinator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marie Lorraine Taylor ဥ William E. Shipley, Sr. 19a. Informant's Name/Relationship (Type. Print) 1576 Wall Dr, Pasadena, MD 21122 Wife Janet Shipley 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Surial 2 ☐ Cremation 3 ☐ Removal from State May 24, 2008 GLen Haven Cemetery 4 Donation 5 ☐Other (Specify) Gregory Fink 22. Name and Address of Facility
Fink Funeral Home, P.A. 426 Crain Hwy S., Glen Burnie, MD M01148 23a. Part 1. Enter the J sease, or shock, I heart fail vie. List lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ne cause on each line. Immediate Cause (Final Physician neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dreade of it july) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transit attending physician and Due to (or as a consequence of) Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify)

1. Decedent's Name (First, Middle, Last)

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and P.O. Division of Vital Records, the funeral director, page 2 should be

9 Be Completed Medical Certification: To

9 Unknown

25. Was case referred to medical

29b. Signature and title of certifier

1 Yes 2 No

examiner'

27. Manner of Death

1 Natural

3 Suicide

29a. Certifier (Check only one)

2 Accident

4 ☐ Homicide

Krish

espirator.

5 Pending

investigation

6 Could not be determined

filled in by within 24 hours a
To the Funeral D

> State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S Greene 31. Date filed (Month, Day, Year) 32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

**ORIGINAL** 

Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

DHMH 17 Rev 1/2001

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 ☐ Yes 2√√ No

State of Maryland / Department of Health and Mental Hygiene amend #1 Per Phy G880 6/13/08 Jh
Reg. No. Reg. No. 3. Time of Death

2. Date of Death Month Year 2008

3: 27 AM

4c. County of Death

Year) 1943

Birthplace (State or Foreign Country)
 MD

Black, White, etc. White

14. Race - American Indian.

USA

Paint

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

20c. Location - City or Town, State Glen Burnie, MD 21061

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

Part II. Other significant conditions contributing to death but not\_resulting in the underlying cause given in Part I. Distress Indrome

24a. Was an

autopsy performed 2 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 2**X**No 1 Tyes

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

2008

32 Registrar's Signature

|   | Please  | Type or Print  |                     |  |   | •                                      | •   | ole.   |  |  |  |
|---|---|--|---------------------|--|---|--|---|--|--|--|--|
|   | 1 - For<br>State<br>Registrar   | State of Mar   | -                   | epartment of I<br>C <i>ertificate of</i>                                   |   |  | 0.0                                       | 00 17001   |  |  |  |
|   | Registrar     Decedent's Name (First, Middle, Last  | st)  |                     | Jertinicate of   | Death                                       | 2. Date of De                          | Reg. No.                                  | 3. Time of Death   |  |  |  |
| Physician<br>/Medical   | GILBERT WILLIA  |  | JR                  |  |   | May                                    | 22, 2                                     | 0418 AM  |  |  |  |
| Examiner  | 4a. Facility Name (If not institution, give   |  |                     | 7  | or Location of Death<br>imore               | ·                                      | 4c. County o                              | of Death<br>Ne   |  |  |  |
| Funeral   | 5. Social Security Number 6. S  | ex 7. Age (  | In yrs. last birth  | day) If Under 1 Year   |   | 8. Date of Bir                         | th  | 9. Birthplace (State or Foreign                                      |  |  |  |
| Director  | 219-28-1118 X   | (X <sup>M 2□ F</sup> 76  | Υ                   | rs.  |   | Aug 6,                                 | 1931                                      | Mary land  |  |  |  |
| aryland<br>show<br>dat  | 10a. State 10b. County  | 1  | 0c. City, Town      |  |   |  |   | 10d. Inside City Limits  |  |  |  |
| the Ma<br>28a-f s<br>notified   | Maryland None  10e. Street and Number   |  | Baltimo             | 10f. Zip Code  |   |  | 10g. Citizen of W                         | 1√X es 2 □ No<br>hat Country?  |  |  |  |
| th with 23a or set be   | 3038 Abel Avenue  |  |                     |  | 21218                                       |  | US  | A  |  |  |  |
| d 21215-0036  filed within 72 hours after death with the Maryland Hygiene. Hygiene. inther than "natural", or items 23a or 288-1 show ant, the Medical Examiner must be notified at examiner must be notified at examiner.  | 11. Marital Status  1 Never Married XX Married  3 Widowed 4 Divorced  | 12. Was Decedent Ev<br>Armed Forces?<br>ALY Yes 2 No<br>If Yes, Give<br>Year or Dates: | er in U.S.<br>Korea | 13. Was Decedent of I<br>If Yes, specify Cub<br>1 ☐ Yes 🔏 No               |   | pecity Yes or No<br>Rican, etc.)       | 14. Race<br>Black<br>Specify:             | - American Indian,<br>t, White, etc.<br>White                        |  |  |  |
| 27 5-0036 thin 72 hours af an "natural", or Medical Exam npleted by I   | 15. Decedent's Ed<br>(Specify only highest gra  | ducation<br>ade completed)   | 16a. I              | Decedent's Usual Occu<br>Give kind of work done<br>life. DO NOT use retire | pation<br>during most of work               | king                                   | 16b. Kind of Business/Industry            |  |  |  |  |
| 27275-00<br>ed within 72 hou<br>ygiene.<br>her than "natura<br>her the Medical E<br>ft, the Medical E   | Elementary/Secondary (0-12)   | College (1-4or 5+)<br>5+   |                     | nne. DO NOT use retire<br><b>Teacher</b>                                   | ea)   |  | Balti                                     | more County  |  |  |  |
| be filed that Hyging of other event, Be Co  | 17. Father's Name (First, Middle, Last)   |  | •                   |  |   |  | , Maiden Surname                          |  |  |  |  |
| Mer arke  | Gilbert William St  |  | 19b.                | Mailing Address (Stree   | Doris La                                    |  | State. Zip Code)                          |  |  |  |  |
| C 22 64 F   | Nancy L Stange  | Wife   |                     | 038 Abel Av  |   |  |   |  |  |  |  |
| O − ± 5 ₹   | 20a. Method of Disposition 1 ★ urial 2 □ Cremation 3 □  | Removal from State   | cemetery            | Disposition (Name of<br>crematory or other pla                             |   | Date                                   |   | City or Town, State  |  |  |  |
| Baltimore, permit. Pages 1 a Department of Hee Important: If Item any Injury or othe  | 4 Donation 5 ☐ Other (Specifical September 1)   | 7  | purarey v           | alley Mem Gar<br>22. Name and Addr   | 1 -   |  |   | m Maryland<br>Funeral Home I   |  |  |  |
| BEEFE   | James Dys   | Con Cua  | R                   | 6500 Y   | ork Road                                    | Baltimo                                | re, Mary                                  | land 21212   |  |  |  |
| Physician<br>/Medical   | 23a. Part1. Enter the disease or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  | a. CONOS   | ed the              | rt failur  |   | or respiratory a                       | arrest,                                   | Approximate Interval Between Onset and Death WALANS                  |  |  |  |
| Examiner  |   | Due to (or as a o  | consequence o       | ):   |   |  |   | 40 mars  |  |  |  |
| sit ed  | Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury   | Due to (or as a c  | consequence of      | );   | •   |  |   | 10 mayo  |  |  |  |
| 6 executed land and urial-transit   | that initiated events<br>resulting in death) Last   | Due to (or as a  | donsequence of      | ny ansara  | <u></u>                                     |  | -   | 40 years   |  |  |  |
| 68760, ifficate be expression as the burial edical Expression and the control of |   | _d   |                     |  |   |  |   |  |  |  |  |
| P.O. BOX 6876 hat the death certificate by d by the attending physic letached for use as the by Physician/Medical   | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?  | 23c. If yes, outcome pf<br>1□Live birth 2  |                     | 3 □Ectopic pregnanc  | Бу  |  | 23d. Date                                 | e of delivery  |  |  |  |
| at the dea<br>by the at<br>tached for   | 1 Yes 2 No  | 4□Pregnant at til<br>9□Unknown   | me of death         | 5 ☐ Other (specify)  |   |  | Wioi                                      | illi Day Fear  |  |  |  |
| be of   | Part II. Other significant conditions of  | contributing to death but  | not resulting in    | the underlying cause gi  | ven in Part I.                              |  |   | ibute to the cause of death? 3 ☐ Probably 4 Dunknown                 |  |  |  |
| al Records,  The law requires the cate has been signe and page 2 should be of Completed by  |   |  |                     |  |   | 24a. Was<br>auto<br>perf               | ppsy p<br>ormed? d                        | Vere autopsy findings available rior to completion of cause of eath? |  |  |  |
|   | 25. Was case referred to medical examiner?  |  | -                   |  | 26. Place of Dea                            |  |   | □Yes 2□No  |  |  |  |
| Of Physic rthis c ral dire  | 1 ☐ Yes 2 No 27. Manner of Death  | Hospital: 1 Inpatient 28a. Date of Injury  |                     | Datierit S DOA   |   |  | idence 6 Othe                             |  |  |  |  |
| ath. or: After ne funer.  | 1 Alatural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day  | Year) In            | jury Wo  | ork?<br>]Yes 2∏No                           |  |   |  |  |  |  |
| DIVISION OF  DIVISION OF  Ital or Attending Phys rs after death. ral Director: After this led in by the funeral di  Certification: Tc   | 3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 Homicide 5 City or Town, State 5 State 6 Could not be determined 5 State 6 City or Town, State 6 City or Town, State 6 City or Town, State 6 City or Town, State 6 City or Town, State 6 City or Town, State 7 State 8 |  |                     |  |   |  |   |  |  |  |  |
| Division or Vita  To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be C   | 29a. Certifier 1. Certifying Ph<br>(Check only one) 2 Medical Exam  | nysician: To the best of<br>miner: On the basis of e<br>and manner state               | examination and     | death occurred at the loor investigation, in my                            | time, date and place<br>opinion, death occu | e, and due to the<br>urred at the time | e cause(s) and ma<br>e, date and place, a | nner as stated.<br>and due to the cause(s)                           |  |  |  |
| To t<br>withi<br>To t<br>com  | 29b. Signature and title of certifier   | . wo   |                     |  | 198946                                      |  | _   | (Month, Day, Year)<br>2, 2008  |  |  |  |
| 12  | 30. Name and address of person who  |  | ath (Item 23a) (7   | Type, Print)  MMONAL   | Hospita                                     | 1. WD                                  |   |  |  |  |  |
| State   | 31. Date filed (Month, Day, Year)   | 22. Registrar  | 's Signature        |  | 110-1                                       |  |   |  |  |  |  |
| Registrar DHMH 17 Rev 1/2001  | MAY 2 7 2001  | Sterine  | K A                 | confi  |   |  |   |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Charlotte Bronski Stanka 5:20A M /Medical 2008 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Towson, Manor Care Dulaney Baltimore MD If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Funeral Birthplace (State or Foreign Country) 1 □ M 2 □ F Months Davs Hours Min. Director 214-40-5764 80 04-06-1928 Baltimore, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or Items 23a or 28a-f show 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 1 X Yes 2 ☐ No Director Woodstock Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3625 Granite Road 21163 **USA** Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Worker Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Bronski Helen Green 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any injury or other trau once. Judith A Plaskowitz Dtr 3625 Granite Road Woodstock Maryland 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State HOly Trinity Russian Ortho May 24,2008 Elkridge Maryland 4 Donation 5 ☐ Other (Specify) nature of Funeral 22. Name and Address of Facility ervice Lizensee Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part1. Enter the discusse, or compositions that caused the death. Do not make the model of the part failure. List only he cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Warner **Physician** 10 yws /Medical Due to (or as a consequence of): Examiner pheumonia A month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner Due to (or as a consequence of). Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) P.0. 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2 1No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P 1 ☐ Yes 2 ☐ No Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 Matural a er death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mian-D K.77 231565 , m

State Registrar

DHMH 17 Rev 1/2001

416

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KIDENE

mior -Dow

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland / Department of Health and Mental Hygiene 1tem 23aPtI,II per dr. 2880 per 16/08dhb 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** 4:55 PM Dwight Showalter 20 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Hospital Bel Air 8. Date of Birth (Month, Day, Year) 06-24-1945 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 ☑ M 2 ☐ F Maryland 219-42-5475 62 **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Jarrettsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1811 Trout Farm Rd 21084 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Printer Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) laryland Be Pages 1 and 2 should be nent of Health and Mental f Health and Menta Item 27 Is marked Ralph Showalter Margaret Ann Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jo Ann Showalter (Wife) 1811 Trout Farm Rd Jarrettsville, MD 21084 other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any injury or ot once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jarrettsville Cem. 05-24-2008 Jarrettsville, MD permit. 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licens Elle Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiogenic Shock Immediate Cause (Final 4 days **Physician** disease or condition resulting in death) /Medical Ischemic Cardiomyopathy 4 days Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 4\_days Acute Myocardial Infarction Box 6876900 Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) o 9□Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Sepsis, Acute Respiratory Distress (Syndrone) 23e. Did tobacco use contribute to the cause of death? 2 Records 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Be Completed Acute Cholecystitis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Gargewood 1 Yes 2 ₽40 Vita 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 X Yes 2 No 1 ☑ npatient 2 ☐ ER/Outpatient 3 DOA 0 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide ō Funeral ##I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Dimedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D005356 ron 30. Name and address of person who completed cause of death (Item 23 Jappe, Print)

Jeffrey Thompson, M.D. 500 Upper ( .500 Upper Chesapeake Dr. Bel Air, MD 21014 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

Registrar

State

7601

OSLER DRIVE, TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. D. .

3 Registrar's Signature

MEHTA

JOGINDER

31. Date filed (Month, Day, Year)

D.

MAY 2 7 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 200<sup>8</sup>8 Physician WAY 21 7:20A В SACHS TILLIE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE 725 MT. WILSON LANE, APT. 210 PIKESVILLE If Under 1 Year | If Under 24 Hrs. (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕏 F (Marin, Pay, Year) 02/21/1917 Months Days Hours 91 223-16-0459 Director Usual Residence of Decedent 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examination at the notified at 1 Tyes 2 No Director BALTIMORE PIKESVILLE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 USA 725 MT. WILSON LANE, APT. 210 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 2 should be filed wi and Mental Hygier is marked other th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be **BRIDGE** BESSIE JACOB ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ges 1 and 2 sh t of Health and If item 27 is n BALTIMORE, MD 54 PENNY LANE, FRANCES SACHS / DAUGHTER 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State REISTERSTOWN, MD BALTIMORE HEBREW 05/23/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition JANS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for as a consequence of Examiner ause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month 5 ☐ Other (specify) been signed by the a should be detached t 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No cate has t page 2 s this certificate 1 Yes Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

State 'Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Registrar's Sign

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 禮  | - 1                  | For State Registrar  | Cert   | ificate of L   | Death                                  |  | Reg. No.   | JUG   | 102   |
|--|----------------------|--|--|--|--|--|--|---|---|
| Physicia   | an                   | Decedent's Name (First, Middle, Last)  |  |  |  | 2. Date of De<br>Month<br>April  | Day  | Year<br><b>08</b>                                   | 3. Time of Death                                |
| /Medic<br>Examin   | er ²                 | Sheila Sheetz  a. Facility Name (If not institution, give street and number)  405 Goethe Street  |  | 4b. City, Town, or Cumberla  | Location of Death                      | •  | 4c. Coun   | ty of Death   |   |
| Funeral<br>Director  |                      | Social Security Number  6. Sex 1 M 2 T  Juan Residence of Decedent   | n yrs. last birthday)  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.         | 8. Date of Bir<br>(Month, Da<br>May 4  | th   | 9. Birthpl<br>Coun                                  | ace (State or Fore<br>try)<br><b>sylvania</b>   |
| how  |                      | Oa. State 10b. County 10   | Oc. City, Town or Loca   |  |  |  |  | 1   | 0d. Inside City Limi                            |
| 28a-f s<br>notified  | Director             | MD Allegany  10e. Street and Number  | Cumber1  | and<br>10f. Zip Code   |  |  | 10g. Citizen o   | of What Coun  | try?  |
| popularies, a second the set and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funeral           | 11. Marital Status  1 Never Married   2 Married   3 Widowed   4 Divorced   12. Was Decedent Eve Armed Forces?   1 Yes, Give Year or Dates:   | 11   | □Yes 2l <b>X</b> No  | ispanic Origin? (Span, Mexican, Puerto | ecify Yes or No<br>Rican, etc.)  | Spe  | lace - Americ<br>lack, White,<br>cify: <b>Whi</b> t | etc.<br>te                                      |
| lygiene.<br>her than "natur<br>nt, the Medical   | Completed            | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  9  | (Give k  | ent's Usual Occup<br>ind of work done of<br>O NOT use retired  | during most of work                    |  | Own  | Hone  | dustry  |
| nd Mental F<br>marked ott<br>imatic even   | To Be                | 17. Father's Name (First, Middle, Last)  John Loar  19a. Informant's Name/Relationship (Type. Print)   | 19b. Mailinç   | Address (Street  | Eileen and Number or Ru                | Loar   |  |   | Code)   |
| nent of Health a<br>int: if item 27 is<br>iry or other trau  | -                    | Frank Sheetz/Spouse  20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State  4 ② Donation 5 □ Other (Specify)   | 20b. Place of Dispos   | Goethe S<br>ition (Name of<br>natory or other place  | 1                                      | mberla<br>Date   |  | <b>21502</b> on - City or To                        | own, State                                      |
| Departri<br>Importa<br>any inju<br>once.   |                      | 21. Signature of Funeral Service Licensee  Ronald S. Wade, Director  23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.  | PER TERR R   | altimore   | tomy Boar<br>. MD 2120                 | )1   |  | imore   | Street  |
| Medical xaminer transit the prival transit street transit tran | al Examiner          | Sequentially list conditions, large learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | consequence of):  astasis consequence of):  consequence of):   |  |  |  |  |   |   |
| e attending<br>d for use as  | Physician/Medical    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome pf 1 □ Live birth 2 4 □ Pregnant at tii 9 □ Unknown  | ☐ Fetal death 3 ☐  | Ectopic pregnanc Other (specify)   | у                                      |  | 23d.   | Date of delive                                      | ery<br>Day Yea                                  |
| signed by the a  | þ                    | Part II. Other significant conditions contributing to death but  | not resulting in the un  | nderlying cause giv  | ven in Part I.                         |  | tobacco use o  |   | the cause of deat<br>bably 4 ∏Unk               |
|  | Completed            |  |  |  |  | 24a. Wa<br>aut<br>per<br>1∐ Yes  | opsy<br>formed?  |   | opsy findings ava<br>ompletion of caus<br>2□ No |
|  |                      |  |  |  | OR District                            |  | (ana)  |   |   |
| After this certifica   | To Be                |  | Year) 28b. Time of Injury  | f 28c. Inju  | iry at<br>ork?<br>]Yes 2 □ No          | ath (Check only<br>Home Re<br>28d. Describe<br>28f. Location                             | sidence 6 Le how injury of   | ccurred   |   |
| fter death.<br>Director: After this certifica<br>In by the funeral director, F   | Certification: To Be | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  1 Could not be determined  28a. Date of Injury (Month, Day) 28d. Date of Injury (Month, Day) 28d. Place of Injury (Month, Day) 28d. Place of Injury building, etc.   | y - At home, farm, str. (Specify)  | f 28c. Inju M 1 Ceet, factory, office  | her: 4 Nursing I                       | ath (Check only  Home K Re  28d. Describe  28f. Location City or T                       | e how injury on (Street and Nown, State)   | d manner as   | ral Route Number                                |
| in 24 hours after death. in 24 hours after death. the Funeral Director: After this certifica   | To Be                | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide  1 Could not be determined  28a. Date of Injury (Month, Day)  (Month, Day)  28b. Place of Injury building, etc.  | Year) 28b. Time of Injury  y - At home, farm, str. (Specify)  my knowledge, death examination and/or in        | f 28c. Inju Wo M 1 Creet, factory, office h occurred at the to execute the street of t | her: 4 Nursing I                       | ath (Check only  Home K Re  28d. Describe  28f. Location City or T                       | sidence 6 C e how injury or (Street and N own, State) ne cause(s) an e, date and pla | d manner as   | ral Route Number,<br>stated.<br>to the cause(s) |
| for death  | Certification: To Be | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier  30. Name and address of person who completed cause of deather in the state of the | Year) 28b. Time of Injury  y - At home, farm, str. (Specify)  if my knowledge, deatl examination and/or in ed. | f 28c. Inju Wo M 1 Creet, factory, office h occurred at the to exercise to the structure of | her: 4 Nursing I                       | ath (Check only) Home X Re 28d. Describe 28f. Location City or 7 e, and due to the time. | sidence 6 C e how injury or (Street and N own, State) ne cause(s) an e, date and pla | dumber or Ru d manner as                            | ral Route Number,<br>stated.<br>to the cause(s) |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Ye aı Month YJAM **Physician** Man ONAR /Medical Ac. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PANDALIS TOWN
FUnder 1 Year | If Under 24 Hrs. | 8. Date of Birth
Min. | Min. | Min. | Month, Day, Oct. 1, BALTIMOSE 6. Sex 7. Age // Drug lost that HOSPICE If Under 1 Year Birthplace (State or Foreign Country) Social Security Number **Funeral** 1920 1 XM 2 F Months 87 132-01-0859 Connecticut Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show amy Injury or other traumatic event, the Medical Examinat must be notified at once. 1 Tyes 2 No Director Greenville SC Taylors 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7 Randy Drive 29687 United States Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ☑Yes 2 ☐ No WWII
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □ Yes 2 No White Specify. Specify: à 3 Widowed 4 □ Dîvorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Phillip Morris Elementary/Secondary (0-12) College (1-4or 5+) Chemical Engineer Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Unknown) Sarah Leonard Joseph Toole, Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
10 Moss View Court, Baltimore, MD 21228 19a. Informant's Name/Relationship (Type. Print)
Wendy Manser - Daughter 20b. Place of Disposition (Name of West Prother place) 20c. Location - City or Town, State 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State Date 4 Departion 5 Dother (Specify)

3 at a uneral Service beense Crematory 5-24-2008 Odenton, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** UNG /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ After this certificate has been situated the funeral director, page 2 should be a second of the seco Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medica examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | **2** | **3** | 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Leath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Patural 5 Pending investigation n 24 hours after death.

Ne Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

MAIN

and address of person who completed cause of death (Item 23a) (Type, Print)

2008

n

Registrar's Signature

W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 130 A M DUVALL THOMPSON MAY 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner TAUSOT CANDLE LIGHT COVE FASTON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 F Months 91 Director 577-36-2203 DETOSTROD, 1916 WASHINGTON DE Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Iteπs 23a or 28a-f show Examiner must be notified at 1 Yes 2 No MD Director EASTON TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AUSUUE 106 WEST FARLE 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Mamied Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 2 3 ☐ Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the M SECRETARY FIVANCIAL ADMINISTRATIO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, æ W. HORMAN THOMPSON MARY ANTHONY BUVALL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINA DONATH/COUSIN ROAD ELLIJAY GA 30536 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HANDUER, MARTIANA ANATOMY WIFTS PEUISITE MAY 27, 2008 4 Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name and Address of Facility
ANDTONY LIFTS PSUS TO HANDULE MD 21076 2233 CONTERMS PAINE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 cans Organic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a ld be detached f P.O. 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1☐ Yes 2 1 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 ☐ Yes 2 ☑ 1√10 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28h. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10046274 2008

State Registrar

31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Commenda \$100 Eash. 070 2/601 MJ-8579

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Urbina 03:00 AM VUVIA 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) 03/27/1983 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under Months Days Hours 9. Birthplace (State or Foreign **Funeral** Days Min. 1 □ M 2 🔀 F 25 El Salvador 217-43-6746 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c, City, Town or Location 10a, State 10h Counts 1 ☐ Yes 🎗 🗓 No Director "natural", or items 23a or 28a-f s dical Examiner must be notified Baltimore Maryland Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1248 Four Winds Way 21221 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2½ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married \*CXYes 2 No Central American Baltimore, Maryland 21215-0036 Specify: à Hispanic 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Jose Urbina Esperanza Gonzalez ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trainonce. Jorge Briceno (Husband) 1248 Four Winds Way, Baltimore, Maryland 21221 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens of Faith 05/28/2008 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Bruzdzinski Funeral Home, p.A. 21 Signature of Fundal Septe Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. te Cause (Final days **Physician** spiratory disea e or condition resulting in death) Medical Due to (or as a consequence of): Examiner preast Vears Metastatic San partially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) nding physician and use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 □-Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Pregnant at time of death 5 Other (specify) the Linknown December 20 2007 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>چ</u> 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 4 No certificate has 2 🗌 No 1 TYes Yes 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other (Specify)} \) Hospital: 1 ☐ Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA မ after death.

Director: After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Injury 1 Hatural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

or Attending To the Hospital within 24 hours a To the Funeral C completely filled Hospital

Registrar

Medical

Joanna M. Peloquin, MD 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

29a. Certifier

(check only one)

32 Registrar's Signature 2008

Ganna M. Keloguen, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

08-03852

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Mary Virginia Vaug   |                | For State                                 | St                                      | ate o                 | f Maryla                   | nd / De               | epartm<br>C <i>ertific</i> | ent of        | Health        | h and              | Menta             | al Hygi      |                     | g. No.                   | 20                    | 08            | 1703                                |
|--|----------------|---|---|-----------------------|----------------------------|-----------------------|----------------------------|---------------|---------------|--------------------|-------------------|--------------|---------------------|--------------------------|-----------------------|---------------|-------------------------------------|
|  | Re             | egistrar<br>Decedent's Name               | (First Midd                             | le Last)              |                            |                       | Cei tillo                  | ale of        | Dean          |                    |                   | 2.           | Date of Death       | 1                        | Voor                  |               | of Death                            |
| Physician/<br>Medical Examine  | •              |   |   |                       | Vou                        | rh+                   |                            |               |               |                    |                   | , k          | Month<br>May 20, 20 | 008<br>008               | Year                  |               | 5 hrs                               |
| Medical Examine  |                | a. Facility Name (if                      | irgir<br>not institution                | on, give s            | Vaus<br>treet and nu       | mber)                 |                            | 4             | b. City, To   | own, or Lo         | cation of         | Death        | - 11                | 4c.                      | County of Dea         | ith           |                                     |
| ·  |                | Sinai Hospit                              |   |                       |                            |                       |                            |               | Baltim        |                    |                   |              |                     |                          | N/A                   | idhalasa /    | State or                            |
| Funeral  | 5              | . Social Security N                       | umber                                   | 6. Sex                |                            | 7. Age (In            | yrs. last bi               | rthday)       | If Unde       | r 1 Year<br>s Days | If Under<br>Hours | Min          |                     |                          | DD/YYYY) 9. E<br>Fore | eian          | I                                   |
| Director   |                | 225-20-                                   | 9553                                    | 1 N                   | л 2 <b>X</b> F             | 7                     | 79                         | Yrs.          |               | Days               | 110010            |              | 11/7                | /19                      | 28                    | Country) V    | 'A.                                 |
|  | Ī              | Isual Residence of                        | Decedent                                |                       |                            | Lea                   |                            |               |               |                    |                   |              |                     |                          |                       | 10d. ins      | side City Limits                    |
| / any  |                | 0a. State                                 | 10b. County                             |                       |                            | 100                   | City, Tow                  |               |               |                    |                   |              |                     |                          |                       | 1 X           | Yes 2 No                            |
| and show   | <u>.</u>       | Md.                                       | Balt                                    | imc                   | re                         |                       | Ba                         | altir         | more          |                    |                   |              | 11                  | 0a. Citiz                | zen of What Co        | ountry?       |                                     |
| the Maryland a or 28a-f sh   |                | 0e. Street and Nur                        | mber                                    |                       |                            |                       |                            |               |               |                    | _                 |              |                     |                          |                       |               |                                     |
| h the  |                | 6110 Ta                                   | lles                                    | Roa                   | .d                         | a de est Fore         | -1-110                     | 12 18/2       | 2<br>S Decede | 120'               | anic Origi        | in? (Spec    | ify Yes or No       | US                       | A. 14. Race - Am      | erican Indi   | an, Black,                          |
| th wit   | Funeral        | Marital Status     Never Marrie           | ed 2 v                                  |                       | 12. Was Dec<br>Armed F     | orces?                |                            | If Y          | es, specif    | fy Cuban,          | Mexican,          | Puerto Ri    | can, etc.)          |                          | White, etc            |               |                                     |
| r dea  | =              | 3 Widowed                                 |   |                       | 1 Yes<br>If Yes, Give Ya   | 2 <b>X</b>            | No                         | 1             | Yes 2         | X No               | specify:          |              |                     | _                        | Specify: B            | lack          |                                     |
| ural"  | <u></u> ≥⊦     | 15. Decedent's Ed                         |   |                       |                            |                       | ted) 16a                   | Deceder       | nt's Hsual    | Occupation         | on (Give k        | kind of wor  | k done              | 16b.                     | Kind of Busines       | ss/Industry   |                                     |
| 2 hou  | Completed      | Elementary/Seco                           |   |                       |                            | 1-4 or 5+)            |                            |               |               |                    | DO NOT            | use retired  | ٠,                  |                          |                       |               |                                     |
| thin 7   | 힏              | 12  |   |                       |                            |                       |                            | Hous          | <u>ewif</u>   |                    |                   |              |                     |                          | wn Hor                | ne            |                                     |
| 215-0036 be filed within 7 and Hygiene.  | 3              | 17. Father's Name                         |   |                       |                            |                       |                            |               |               | 1                  |                   |              | irst, Middle,       |                          |                       |               |                                     |
| be fill  | 8              | Raine                                     | e Dav                                   | enp                   | ort                        |                       |                            | 10h Mailin    | a Address     | s /Street          | Gra<br>and Num    | CE L         | aven)               | OOT<br>mber, C           | City or Town, Si      | tate, Zip Co  | ode)                                |
| 21<br>hould I<br>hould I<br>is mai<br>stric ev   | ٩Ī             | 19a. Informant's N                        |   |                       | pe, Print )                |                       |                            |               |               |                    |                   |              | ltimo               |                          |                       | 21207         | _                                   |
| MD and 2 sho alth and 2 sho alth and 2 rawmatis  | -              | Walter<br>20a. Method of Dis              | Vaus                                    | ght                   |                            | _                     | 20b. Plac                  | e of Dispo    | sition (Na    | me of cen          | netery,           | , <u>ba</u>  | Date                | 20c.                     | Location - City       |               |                                     |
| or He of He If ite   |                | 1 X Burial 2                              |   | on 3                  | Removal                    | from State            | i                          | natory or o   |               |                    |                   | 5/29         | 2/200               | Q B                      | Altimo                | ore           | Md                                  |
| Pag<br>ment<br>tant:   | -              | 4 Donation 5                              | Other                                   | Specify:              | -                          |                       | Arb                        | utus          | Name and      | nete.<br>d Address | of Facility       | y 20         | 5/200               | 9 1                      | A L C LIN             | J1 C,         | 74                                  |
| Baltimore, MD 21215-0036 permit: Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.                   | +              | 21 Sign ture of Fi                        | un-rai Serv                             |                       | SEV                        |                       |                            | E             | ster          | Br                 | othe              | ers l        | tuner<br>B          | aı<br>alt                | imore                 | ce, '<br>.Md. | 21217                               |
| Physician  | $\dashv$       | 20a. Part I. Enter t                      | he disease,                             | er compl              | ications that              | baused the            | e death. Do                | not enter     | the mode      | of dying,          | such as c         | cardiac or i | respiratory a       | rest, sh                 | ock, or heart         | App<br>Bet    | roximate Interval<br>ween Onset and |
| /Wedical   | 1              | failule. List of                          | my one out                              |                       | ch line.<br>Exsanguit      | -                     |                            |               |               |                    |                   |              |                     |                          |                       |               | Death                               |
| aminer   |                | Immediate Cause<br>or condition result    | ing in death                            | )                     | Due to (or as              | a consequ             | ence of):                  |               |               |                    |                   |              |                     |                          |                       |               |                                     |
|  | .              | Sequentially list c                       | onditions,                              |                       | Perforatio                 |                       |                            | artery d      | luring s      | tent pla           | cemen             | ι            | _                   |                          |                       |               |                                     |
|  | Examine        | if any, leading to i cause. Enter Und     | lerlying Cau                            | se .                  | pua to (or as<br>Hypertens | sive Athe             | erosciero                  | otic Card     | diovasc       | ular Dis           | ease              |              |                     |                          |                       |               |                                     |
| W =  | хаш            | (Disease or injury<br>events resulting in | that initiate<br>death) Las             | a •                   | Due to (or as              |                       |                            |               |               |                    |                   |              |                     |                          |                       |               |                                     |
| be executed ician and inial - transit  | 표              |   |   | d.                    |                            |                       | -                          |               |               |                    |                   |              |                     |                          |                       |               |                                     |
|  | dical          | UNPENDE                                   | D                                       |                       | AMENDE                     |                       |                            |               |               |                    |                   |              |                     | 12                       | 3d. Date of de        | livery        |                                     |
| OX 68760,<br>eath certificate be ex<br>attending physician<br>for use as the burial  | /Me            | IF FEMALE:<br>23b. Was deceder            | nt pregnant i                           | n the                 |                            | s, outcome<br>e birth | of pregnar                 |               | Fetal deat    | h 3                | Ectop             | ic pregnar   | псу                 |                          | Month                 | Day           | Year                                |
| K 68<br>n certi<br>endin   | ciar           | past 12 mont                              |   |                       | 4 Pre                      | gnant at tir          | ne of death                | . ==          | Other (Sp     | pecify)            |                   |              |                     | Ì                        |                       |               |                                     |
| Box 68760<br>e death certificate b<br>the attending physicate for use as the bh  | Physician/Me   | 1 Yes 2 🗸                                 |   | Unknowr               | 90111                      | known                 |                            | using to the  | o un dorly    | DO 631156          | given in F        | Part I       | 23e. Dio            | tobaco                   | co use contribu       | te to the ca  | use of death?                       |
| P.O. es that the igned by  | by P           | Part II. Other sig                        |   | nditions              | contributing               | to death t            | out not rest               | uiting in the | e undeny      | ng cause           | givenini          | GIT II       |                     |                          | <b>✓</b> No 3         |               |                                     |
| S, P   | edk            | Diabetes                                  | meilitus                                |                       |                            |                       |                            |               |               |                    |                   |              | 24a. Wa             | as an                    | 24b. We               | re autopsy    | findings available                  |
| w req  | plet           |   |   |                       |                            |                       |                            |               |               |                    |                   |              | ре                  | topsy<br>rform <u>ed</u> | ? dea                 | ath?          | etion of cause of                   |
| Reco   | Completed      |   |   |                       |                            |                       |                            |               |               |                    |                   | (Ob lo       |                     | s 2                      | No 1                  | Yes           | 2 No                                |
| ial Filan:   | Be             | 25. Was case ref examiner?                | erred to med                            |                       | Hospital: 1 ✓              |                       |                            | R/Outpatie    | 201 2         | DOA                | Other             | th (Check o  | g Home 5            | Res                      | idence 6              | Other:        |                                     |
| Nysic  | 2              | 1 Yes 27. Manner of De                    | 2 No                                    |                       | 280 D                      | ate of Injur          | / Ta                       | 28b. Time o   |               |                    | ury at Wo         | rk2          | 28d Describ         | ne how                   | injury occurred       |               |                                     |
| n of   |                | 1 Natural                                 | -                                       | Pending               | Unkn                       | onth, Day,Yea         | ar)                        | UNKNOV        |               |                    | Yes 2             |              | Perforation         | n of f                   | emoral arte           | ery during    | g procedure                         |
| SiOI<br>Attender death   | cati           | 2 🗸 Accident                              |   | nvestiga              | 28e. F                     | Place of Inju         | ıry - At hon               | ne, farm, s   | treet, facto  | ory, office        | building,         | etc.         | 28f. Locatio        | n (Stree                 | et and Number         | or Rural R    | oute Number, City                   |
| Division of Vital Records, tat or Attending Physician: The law requir is after death.  *A Director: After this certificate has been side in by the funeral director; page 2 should the   | Certification: | 3 Suicide                                 |   | Could no<br>determine | be                         | ify) Hos              |                            |               |               |                    |                   |              | 2401 West           | Belve                    | )<br>dere Avenue      | , Baltimor    | e,MD                                |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b |                | 4 Homicide                                |   | g Physic              | ian: To the                | best of my            | knowledge                  | e, death oc   | curred at     | the time,          | date and p        | place, and   | due to the c        | ause(s)                  | and manner a          | s stated.     | 100(5)                              |
| thin 2<br>the P  | Medical        | (Check only one) 2                        | Medical                                 | Examine               | er:On the ba               | sis of exam           | ination and                | d/or investi  | igation, in   | my opinio          | on, death         | occurred a   | at the time, d      | ate and                  | place, and do         |               | Se(S)                               |
| F.W.F.O  | Me             | 29b. Signature a                          | nd title of ce                          | ertifier              |                            |                       |                            |               |               | 29c. Licer         |                   | ег           |                     | - 1                      | d. Date signed        | •             | /ay, rear)                          |
|  |                | 1/1                                       | Eista                                   | J's                   | 1-671                      | Mr                    |                            |               |               | 0.0                | .M.E.             |              |                     |                          | /lay 21, 200<br>      |               |                                     |
| 11   | Ų              | 30. Name and a                            |   |                       | com ted                    | cause of de           | eath (Item 2               | 23a)          | 44 D===       | n Ctract           | Politic           | nore M       | D 21201             |                          |                       |               |                                     |
|  |                | Tasha Gr                                  |   |                       | Assistan                   |                       |                            |               | iiPeni        | 11 211661          | , paluff          | noie, IVI    | J 2 120 1           | _                        |                       |               |                                     |
| Si<br>Regis  | tate           | 31. Date filed (M                         | MAY 2                                   |                       | 008                        | . Registrar           | s Signatur                 | . 1           | and?          | 1                  |                   |              |                     |                          |                       |               |                                     |
| DHMH 17 Rev 1/2  |                | •   | 111111111111111111111111111111111111111 |                       |                            | WINDS OF STREET       | <del>, ,,,</del>           | ORIGII        | NAL           |                    |                   |              |                     |                          |                       |               |                                     |
| DUMBUL IN DEV 1/2  | -001           |   |   |                       | CRAC                       |                       |                            |               |               |                    |                   |              |                     |                          |                       |               |                                     |

|  |  |                   |   | se Type or<br>State o                    | <b>Print in Bl</b> of Maryland                              |                        |   |                   |                        | =                      |            | -   |  |
|--|--|-------------------|---|--|---|------------------------|---|-------------------|------------------------|------------------------|------------|---|--|
|  |  | -                 | For<br>State<br>Registrar   |  | ,   |                        | tificate of                             |                   |                        |                        | Reg. No.   | 0000  | 17031  |
|  | Physicia   | an                | 1. Decedent's Name (First, Middle   | le, Last)                                |   |                        |   |                   |                        | 2, Date of De<br>Month | Day        | Year  | 3. Time of Death                               |
|  | /Medic   | al                | Dorothy A.  | Wood                                     |   |                        | 4h City Tayya a                         | - Lonation        | of Death               | MAY                    | 27         | 2008<br>County of Death                       | 7:15 a <sup>M</sup>                            |
|  | Examin   | er                | 4a. Facility Name (If not institution 1549 Baywood R                          |  | mber)   |                        | 4b. City, Town, o                       |                   | or Death               |                        |            | Anne Aru                                      |  |
| F  | uneral   |                   | 5. Social Security Number   | 6. Sex                                   | 7. Age (In yrs. la:   | st birthday)           | If Under 1 Year<br>Months Days          | If Under<br>Hours | 24 Hrs.<br>Min.        | 8. Date of Bit         | rth        | Q Rinth                                       | place (State or Foreign<br>intry)              |
| D  | irector  |                   | 216-30-7162   | 1 □ M 2 <b>X</b> F                       | 77  | Yrs.                   | Wioritins Days                          | 110013            | 141111.                | NOV 16                 | 1930       | 0 Mar   | yland  |
| fand   | MO III   |                   | Usual Residence of Decedent  10a. State 10b. County                           |  | 10c. City,  | Town or Loc            | cation                                  |                   |                        |                        |            | T   | 10d. Inside City Limits                        |
| Mary   | a-f sh   | ctor              | MD Anne   | Arundel                                  | Pa  | sadena                 | a                                       |                   |                        |                        |            |   | 1 □Yes 2 XNo                                   |
| ith the  | or 28  | Director          | 10e. Street and Number  |  |   |                        | 10f. Zip Code                           |                   |                        |                        | 10g. Citi  | izen of What Cou                              | intry?   |
| ath w  | s 23a  | eral              | 1549 Baywood  | T  |   | 140.11                 | 21122                                   |                   | -1-0.40-               |                        |            | USA   | to a feature                                   |
| fter de  | irem   | Funeral           | 11. Marital Status 1 ☐ Never Married 2 ☐ Mar                                  | Armed Fo                                 |   |                        | Vas Decedent of F<br>Yes, specify Cub   | an, Mexicai       | igin? (Sp<br>1, Puerto | Rican, etc.)           | 0-         | <ol> <li>Race - Amer Black, White,</li> </ol> |  |
| ours a   | Exan   | by                | 3 X Widowed 4 □ Divorced  | If Yes, Gi                               |   | 1                      | □Yes 2No                                | Specify:          |                        |                        |            | Specify: W                                    | hite   |
| 72 hc  | "natural", or<br>adical Exami  | letec             | 15. Deceder<br>(Specify only highe  | nt's Education<br>est grade completed)   |   | (Give I                | lent's Usual Occup<br>kind of work done | durina mos        | t of work              | ing                    | 16b. Kii   | nd of Business/li                             | ndustry  |
| within   | than   | Completed         | Elementary/Secondary (0-12)   | College (                                | 1-4or 5+)   | Homen                  | 00 NOT use retired<br>naker             | a)                |                        |                        | (          | Own Home                                      |  |
| be filed within 72 hours after death with the Maryland | nd in rygener.  the interest of the man state of the most be notified at event, the Medical Examiner must be notified at | Be C              | 17. Father's Name (First, Middle,   | Last)                                    |   |                        |   | 18. Mothe         | er's Nam               | e (First, Middle       |            |   |  |
| should b   | and mental rygiene. is marked other than aumatic event, Ine M  | 2                 | Henry Volk  | an                                       | · · · · · · · · · · · · · · · · · · ·                       |                        |   | El:               | izabe                  | eth D                  | urfo       | rd  |  |
| 12 sh  | 7 is marke<br>traumatic  | Н                 | 19a. Informant's Name/Relations  Michele Wood -                               |  |   |                        | g Address (Street<br>Baywood            |                   |                        |                        |            | r Town, State, Z.<br>21122                    | ip Code)                                       |
| 1 and  | tem 2  | 1                 | 20a. Method of Disposition  | Daugitter                                | 20b. Pla  |                        | sition (Name of natory or other place   |                   |                        | Date                   |            | cation - City or T                            | own, State                                     |
| Pages  | int: If  |                   | 1 ☐ Burial 2 🔀 Cremation 4 ☐ Donation 5 ☐ Other (5                            |  | State   |                        | natory or other place<br>matory,        | :                 | 5/28                   | /2008                  | Ba1        | timore,                                       | MD   |
| permit.  | Important: If Item 27 is any Injury or other tra   | П                 | 21. Signature of Funeral Service  | teven H.                                 |   |                        | Name and Addre                          |                   |                        |                        |            | The second second second                      |  |
| ا ق  | 2 5 6 9  |                   | 23a. Part 1. Enter the disease, o   | will a state of the total                | noused the death  |                        | 299 Fred                                | lerick            | Roa                    | ad, Bal                | timo       | re, MD  | 21228<br>Approximate                           |
| Dha  | rainian  | 0. 3              | shock, or heart failure. List   | only one cause on e                      | each line.  | DO HOT BING            | Had                                     | T, such           | calda                  | or respiratory a       | arrest,    |   | Interval Between<br>Onset and Death            |
|  | /sician<br>ledical   |                   | disease or condition<br>resulting in death)                                   | a. Doe to                                | (or a consique  | ence of): 📝            | 11/11                                   |                   | 411                    | ) (                    |            | -   | JYE MY)  |
| Exa  | aminer   |                   | Service Hally But Service   | DI.                                      | stell)  | 1                      | rellito                                 | <u> </u>          |                        |                        |            |   | loyears  |
| 31   | V ti   | nine              | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to                                   | (or as a conseque   | ence of):              |   |                   |                        |                        |            |   | l  |
| execut   | n and<br>ial-transit   | Examine           | that initiated events<br>resulting in death) Last                             | c  | (or as a conseque   | ence of):              |   |                   |                        |                        |            |   |  |
|  | w =  |                   |   | d  |   |                        |   |                   |                        |                        |            |   |  |
| la reruires that the death certificate be              | ling pt<br>e as th   | Physician/Medical | IF FEMALE:  |  |   |                        |   |                   | -                      |                        | Т          |   |  |
| aath o   | attendin<br>for use  | ian/              | 23b. Was decedent pregnant in the past 12 month?                              | 1 Live                                   | tcome of pregnand<br>birth 2□Fetal c<br>mant at time of dea | death 3□               | Ectopic pregnand<br>Other (specify)     | СУ                |                        |                        | ;          | 23d. Date of deli<br>Month                    | very<br>Day Year                               |
| the d  | ed by the detached to  | nysic             | 1 □ Yes 2 □ No<br>9 □ Unknown   | 9 ☐ Unkr                                 |   | au                     | Tottler (specify)                       |                   |                        |                        |            |   |  |
| s that   |  | by P              | Part II. Other significant conditi  | ons contributing to d                    | eath but not result   | ting in the un         | derlying cause giv                      | en in Part I      |                        | 23e. Did               | tobacco u  | use contribute to                             | the cause of death?                            |
| reculir  | been signe<br>should be  |                   |   |  |   |                        |   |                   |                        | 1 🗆                    | Yes 2[     | □ <del>No  </del> 8 □ Pro                     | obably 4 Unknown                               |
| e la   | ha:  | Completed         |   |  |   |                        |   |                   |                        | 24a. Was               |            | 24b. Were aut<br>prior to c<br>death?         | topsy findings available ompletion of cause of |
| nn: The  | certificate ha   | မ<br>င            | 25. Was case referred to medica   | i I                                      |   |                        |   | OF Disco          | of Doot                | 1 ☐ Yes                | 2 PNo      | 1 ☐ Yes                                       | 2 No -   |
| ysicia   | Si je  | 0 0               | examiner?   | Hospital:                                | Inpatient 2 ☐ E   | R/Outpatien            | t 3 DOA Oth                             | or:               |                        |                        |            | 6 □Other (Spec                                | eify)  |
| ng P   | rer  | on:T              | 27. Manner of Death 1 ☐ Hatural 5 ☐ Pendir                                    | 28a. Date                                | of Injury 2<br>oth, Day, Year)                              | 28b. Time of<br>Injury | 28c. Inju                               | ry at<br>rk?      |                        | 28d. Describe          | how injur  | y occurred                                    |  |
| Attending Physician:                                   | tor: A   | icati             | 2 ☐ Accident investi<br>3 ☐ Suicide 6 ☐ Could                                 | gation                                   | of Injury . At hom  | no form etre           |   | Yes 2□            | No                     | 28f Location           | /Ctraat an | d Number or Bu                                | ral Route Number,                              |
| al or A  | d in by  | Certification:    | 4 Homicide determ   | nined 20e. Place<br>build                | of Injury - At homing, etc. (Specify)                       | ic, iaiii, siie        | set, lactory, office                    |                   |                        | City or To             |            |   | rai noute reutiber,                            |
| lospita  | unera<br>unera<br>ely fille  | edical C          |   | ng Physician: To the<br>Examiner: On the |   |                        |   |                   |                        |                        |            |   |  |
| the P  | To the Funeral Director: All completely filled in by the fu  | Medi              | one)  29b. Signature and title of certifie                                    | and man                                  | her stated.   |                        | 29c. Licens                             |                   |                        |                        |            | te signed (Month                              |  |
| 2 · ·  | 58   | -                 | 9 POW   | Km                                       | nm  |                        |   | 1200              | 9V                     |                        |            | アタチ   | OX   |
|  | in   |                   | 30. Name and address of person  | who completed caus                       | se of death (Item 2   |                        |   | n L               | (A)                    | 2 2                    | 1/2        | Rit   | 1 (1)  |
|  | 10   |                   | Ellott and  | saty.                                    | 141   |                        | iden 1                                  | Kunk              | 0                      | ruf (                  | Hen        | 20141   | e, 49, 406                                     |
|  | Sta  | 2.3               | 31. Date filed (Month, Day, Year)   | / B2. F                                  | Registrar's Signatu   | ii C                   |   |                   |                        |                        |            |   | /  |

ORIGINAL

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** enevo \*\*/Medical 4a. Facility Name (If not institution, give street and number) cation of Death 4c. County of Death **Examiner** If Unde Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 M 2 F Yrs. 8-29-1948 **Director** 59 212-58-S.C. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 23a or 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Heath and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 □ No **Funeral Director** Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1201 N. Central Avenue 21202 S 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No if Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify Black þ 3 ☐ Widowed 4 ☑ Divorced Completed Unk 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) unk Elementary/Secondary (0-12) College (1-4or 5+) N/Allth grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willie Lee Evans 2 Unknown 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Central Avenue Balto, MD 21202 Antoinette Robinson 1201 Ν. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pk 5-27-08 Randallstown, MD King Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 21202 1101 E. North Avenue Balto, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. hedostad Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine or Attending Physician; The law requires that the death certificate be executed and burial-trai resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE ase 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 ponths? 1 ☐ Yes 2 No Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2006 3 Probably 4 Unknown 1 TYes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes perform certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 npatient Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA Certification: To this nours after death. neral Director: After this filled in by the funeral d 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day 5 □ Pending investigation 1 🗌 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral I To the Hospital Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** FRANCES WILSON, JR. 1015 AM MAY 39 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** BALTIMORS Ausur 3030 PARKUILLE TAYLOR 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 2 M 2 □ F Months Days Hours 217-40-8734 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Director MD PARKVILLE BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA AUSJUE 21234 3030 TAYLOR by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 pd Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 21215-0036 Specify Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRINTING PRINTER 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be FRANCES WILSON MARY THURSS MILLER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 91734 2907 ALDEN ROAD 15157617 BALTIMONS MARY WALTON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MATOMY WIFTS DEWSTRY MAY 27 2008 HAND VLIR MARYLAUD 4 Monation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
ANATOMY LIFTS TEUSTRY
7522 CONELLEY ERIVS HAUDUER, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic bladder cancer Physician disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, as the IF FEMALE: asn 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy perform 1 Yes 2 No Division or Vital To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \sum Nursing Home 5 \overline{\overli Hospital: 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Medical Certification: To this within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide f 😭 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40850 May 22, 2008 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Franklin Squar Dr. Bretimir MD 21237 OTTAVIANO 9103 2. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician**  $\mathbf{P}^{\mathsf{M}}$ 2008 Rose Marie Wilhelmi May /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days **Funeral** 1 □ M 2**X** F 14 NY Oct. 1930 060-24-8312 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifited at 1 ☐ Yes 2 ☐ No Director Baldwin MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21013 8 Marmaduke Ct. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 2 **№**No 1 ☐ Yes 2 ☐ No Specify: Specify: white Ś 3√ Widowed 4 Divorced MING Maryland 21215-003 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose M. Warren Leon W. Laws 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health an Important: If item 27 Is 8 Marmaduke Ct., Baldwin, MD 21013 Christine M. Wilhelmi/daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 M Burial 2 ☐ Cromation 3 ☐ Removal from State St. John's Church Cem. 5/29/08 Hydes, MD Donation 5 □ Other (Specify) 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 mature of Eunera Lemmon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) chronic obstructive pulmonary disease 10 years Physician /Medical Due to (or as a consequence of): Examiner Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to tor as a consequence off. Examiner e attending physician and d for use as the burial-transit certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an ate has b page 2 s or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To After this ieral Director: After the filled is by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the h

State Registrar 31. Date filed (Month, Day, Year) MAY 2 7 2008

Cyuthia Small Mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Cynthin Soriano MD 32. Begistrar's Signature S. S. S. S. S. Sand

6701 N. Charles St. Baltimore MD 21204

29c. License number

D0051347

29d. Date signed (Month, Day, Year)

|                        | 1 - State<br>Registrar   |  | Certificate of  | Health and M<br><i>Death</i>  | Reg. N  | 10. ZUU8  | 1/03  |
|------------------------|--|--|---|---|---|---|---|
| ician<br>dical         | 1. Decedent's Name (First, Middle, Las<br>Emma Louise  | Abrams   |   |   |   | Day Year  | 3. Time of Death 23:20  |
| niner                  | 4a. Facility Name (If not institution, give Laurel Regional  5. Social Security Number 6. S.   | Hospital   | Laurel  |   | 8. Date of Birth  | Prince G  | eorge's   |
| al<br>or               |  | ex 7. Age (In yrs. last)   | Yrs. Months Days  | Hours Min.  | Month, Day, Yea   | L915 F1o  | place (State or Foreigi<br>ntry)<br>rida  |
| ector                  | 10a. State 10b. County   |  | own or Location  Ver Spring   |   | 10-6  | Citizen of What Cou   | 10d. Inside City Limits 11√ Yes 2 No  |
| Funeral Directo        | 8505 Springvale R  | Load  12. Was Decedent Ever in U.S.  | 10f. Zip Code<br>20904  | Jianasia Origina (Sp.   | Ur  | nited Sta   | tes   |
| 2                      | 3 ⅓Widowed 4 ☐ Divorced  | Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:  | 13. Was Decedent of I<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☑ No  |   | Rican, etc.)  | Black, White  |   |
| Completed              | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)<br>12 years  | lucation 16<br>de completed) College (1-4or 5+)  | 6a. Decedent's Usual Occu<br>(Give kind of work done<br>life. DO NOT use retire<br>Supervisor   | durina most of worki  | ing   | Kind of Business/li   | ndustry   |
| To Be Co               | 17. Father's Name (First, Middle, Last)  |  | Supervisor  |   | First, Middle, Maid<br>sie Denefi   | en Surname)   |   |
|                        | 19a. Informant's Name/Relationship (1<br>Barbara Walker –  |  | 9b. Mailing Address <i>(Street</i> ) 5601 - 1st St  |   |   |   |   |
|                        | 20a. Method of Disposition  1X Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify  21. Signature of Funeral Service Union   | Removal from State Ft . I  |   | ice) ¦  | 4, 2008 I<br>ewart Fune   |   | , MD<br>, Inc.  |
| Examiner               | 23a. Part \ Enter the disease, or com shock, or deart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, If any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that imitated events   | one cause on each line.  | ith Respirato<br>ce of):<br>pation  | _   |   |   | Approximate<br>Interval Between<br>Onset and Death  |
| dical                  |  | Due to (or as a consequence do a consequ | osis  |   |   | 23d. Date of deli   |   |
|                        | 23b. Was decedent pregnant   | 1 ☐ Live birth 2 ☐ Fetal dea   |   | cy  |   |   |   |
| hysician/Me            | in the past 12 months?<br>1 ☐ Yes 2 ☒ No<br>9 ☐ Unknown  | 4□Pregnant at time of death<br>9□Unknown   |   |   |   | Month   | very<br>Day Year  |
| by Phy                 | Part II. Other significant conditions c  | 9□Unknown  | 5 ☐ Other (specify) _   | ven in Part I.  |   | Month to use contribute to  | Day Year the cause of death?  |
| Completed by Phy       | Part II. Other significant conditions o  | 9□Unknown  | 5 ☐ Other (specify) _   |   | 1  Yes  24a. Was an autopsy performed 1 Yes 2   | Month  ouse contribute to  2 🗷 No 3 🗆 Pro  24b. Were au prior to co   | the cause of death?  bably 4 Unknow  topsy findings availation of cause o   |
| To Be Completed by Phy | Part II. Other significant conditions of the con | 9□Unknown  ontributing to death but not resulting  Hospital: 1 ☑Nnpatient 2 □ ER/  | g in the underlying cause gi  | 26. Place of Death<br>her:<br>4∐ Nursing Ho                                 | 1  Yes  24a. Was an autopsy performed 1  Yes 235  n (Check only one)  me 5  Residence   | Month  ouse contribute to  2 A No 3 Pro  24b. Were au prior to o death? 1 Yes  6 Other (Spec  | Day Year the cause of death? bably 4 □Unknow topsy findings availab ompletion of cause of                               |
| To Be Completed by Phy | Part II. Other significant conditions of the con | 9☐Unknown  ontributing to death but not resulting  Hospital: 1 ☐¥inpatient 2 ☐ ER/  28a. Date of Injury (Month, Day Year)  | on 5 ☐ Other (specify) ☐  g in the underlying cause given the underlying c | 26. Place of Death<br>her: 4 □ Nursing Ho<br>iry at<br>ork?<br>□ Yes 2 □ No | 1   Yes  24a. Was an autopsy performed 1   Yes 2x   | Month  ouse contribute to  2 No 3 Pro  24b. Were au prior to c death? 1 Yes  6 Other (Specially) and Number or Ru                     | the cause of death?  babbly 4 □Unknow  topsy findings availate  ompletion of cause of  2 □ No                           |
| Be Completed by Phy    | Part II. Other significant conditions of the significant condition | 9☐Unknown  ontributing to death but not resulting  Hospital: 1 ☐ Inpatient 2 ☐ EP/  28a. Date of Injury (Month, Day Year)  28e. Place of injury - At home,   | outpatient 3 □ DOA Other (specify) □  Outpatient 3 □ DOA Other (specify) □  Outpatient 3 □ DOA Other (specify) □  Double of Injury Mount of I | 26. Place of Death her: 4 \  Nursing Ho  lry at rk?  Yes 2 \  No            | 24a. Was an autopsy performed 1 Yes 2 1 Yes 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 2 1 Yes 2 | Month  ouse contribute to  2 No 3 Pro  24b. Were au prior to death? 1 Yes  6 Other (Special Property occurred)  and Number or Rulate) | the cause of death?  babably 4 □Unknow  topsy findings availab  ompletion of cause of  2 □ No  cify)  ral Route Number, |

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                     |  |                     | 1-               | For<br>State<br>Registrar  |  | State of M  | aryıan              | -   |                                   |                       | leaith and<br>Death                                  | мептат ну                           | /gien<br>Reg. N         |   |  |
|---------------------|--|---------------------|------------------|--|--|---|---------------------|---|-----------------------------------|-----------------------|--|-------------------------------------|-------------------------|---|--|
|                     | Physici<br>/Medic  |                     | 1. D             | ecedent's Name (FAWAZ  | First, Middle, Last<br>AGHA                          | )   |                     |   |                                   |                       |  | 2. Date of D<br>Month               | eath<br>Da              | ay Year 2008                                      | 3. Time of Death 00 - 27 M                       |
|                     | Examir<br>Funeral<br>Director  |                     | 70/<br>5. S      |  | RagioNA<br>ber 6. Se                                 |   | ) (2<br>je (In yrs. | last birthday)                                | 4b. City,  If Under  Months       | 54                    | If Under 24 Hrs Hours Min                            | 8. Date of B                        | rth<br>a <i>y, Year</i> |   | place (State or Foreign<br>ntry)                 |
|                     | D D  | or                  | Usu              | al Residence of De   |  | ico   |                     | y, Town or Lo                                 |                                   | ali                   | sbury  | 1//6/1                              | 942                     | •   | of Syria<br>Od. Inside City Limits<br>1∐Yes 2☑No |
|                     | a or 28a-  | Il Direct           |                  | Street and Number  |  | a d   |                     |   | 10f. Zip                          | Code                  | .804   |                                     | 10g. C                  | itizen of What Cour                               | ntry?  |
| 20                  | ges 1 and 2 should be filed within 72 hours after death with the Maryland<br>to fleath and Mental Hygiene.  If the m 21st marked other then "netural; or Items 22s or 28s-f show<br>of other treumatic event, the Medical Examinar must be redilised at  | by Funeral Director |                  | Marital Status  Never Married  Widowed 4 [   |  | 12. Was Decedent<br>Armed Forces<br>1 ☐ Yes 2 1<br>If Yes, Give<br>Year or Dates: | ,                   |   | Was Deced<br>f Yes, spec<br>1 Yes |                       | lispanic Origin? (S<br>an, Mexican, Puer<br>Specify: | Specify Yes or N<br>to Rican, etc.) | 0-                      | 14. Race - Americ<br>Black, White,<br>Specify: Wh | etc.   |
| Maryiand 21215-0036 | within 72 hou<br>ane.<br>then "netura<br>ha Medical E  | Completed           | E                | (Specify<br>lementary/Secondary  | i. Decedent's Edu<br>only highest grad<br>ary (0-12) | ucation<br>le completed)<br>College (1-4or  | 5+)                 |   | kind of wo<br>DO NOT us           | rk done<br>se retired | during most of wo                                    | rking                               |                         | Kind of Business/In                               |  |
| ומווח ד             | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other then<br>eumatic event, the Ms   | To Be Co            | 17.              | Father's Name (Fir<br>Mustafa  |  |   |                     | <u> Du</u>                                    | sine                              | SS                    |  | me (First, Middle                   | e, Maide                | estaura<br>n Sumame)                              | nt   |
|                     | 1 and 2 should<br>Health and Men<br>Iem 27 is marke<br>other treumatic   |                     |                  | . Informant's Name<br>Dbaydah  | Agha/S   |   | 1                   | 605   | Par                               | ker                   | and Number or R                                      | Salisb                              | ury                     |   | 1804   |
| DE L                | and and and and and and and and and and  |                     | ,                | 4 ☐ Donation 5 [   | Cremation 3 □F<br>□ Other (Specify)                  |   | 0                   |   | natory'or o<br>l Buk              | ther plac<br>as       | Cem 5/   |                                     | Fε                      | ederalsb  | urg, MD  |
| 0                   | permit. Departr Importe any init   |                     |                  | Signature of Funer   | tine?  | tications that cause ne cause on each I   | Le_                 | FI  | ampt                              | om                    | runera.  | т поше                              | PP                      | ot.Feder  | alsburg MD 21632 Approximate Interval Between    |
|                     | Medicale be executed (Medicale as the purial-transit as the purial | Examiner            | Sequence of that | nediate Cause (Fin<br>pass or condition<br>ulting in death)<br>uentially list condition<br>by leading to immisse. Enter Underly<br>is of Disease or injuinitiated events<br>ulting in death) Las | tions, diata   | a. Due to (or as  | a consequence       | ESTIN<br>uence of):<br>15 TRI (<br>uence or): | AL<br>C                           |                       | BLEE   |                                     |                         |   | Onset and Death                                  |
| .O. BOX 00/00,      | The taw requires that the death certificate be attending physici page 2 should be detached for use as the bu   | Physician/Medical   |                  | EMALE:  Was decedent pr in the past 12 mg 1 Yes 2 N 9 Unknown  | egnant<br>onths?                                     | d   | 2 Feta              | Ideath 3□                                     | Ectopic pr<br>Other (sp           |                       | ,  |                                     |                         | 23d. Date of delive                               | ery<br>Day Year                                  |
| L (Spin)            | w requires that<br>been signed be<br>should be det   | by                  | Part             | II. Other significa  | nt conditions co                                     | ntributing to death t   |                     | ulting in the u                               | nderlying c                       | ause giv              | en in Part I.  |                                     | Yes 2                   | 1   | pably 4 Unknown                                  |
|                     |  | e Completed         | 25.              | Was case referred  | to_medical   |   |                     |   |                                   |                       | 26 Place of De                                       | auto                                | ormed?                  | death?  | psy findings available<br>impletion of cause of  |
| 5                   | Jing Phys<br>n.<br>After this<br>funeral dir   | ation: To B         | 27.              | examiner? 1 Yes 2 No Mann of Death 1 Natural   | 5 Pending investigation                              | Hospital: Inpati<br>28a. Date of Inju<br>(Month, De                               |                     | ER/Outpatien<br>28b. Time of<br>Injury        |                                   | 8c. Injur<br>Wor      | er: 4 🗆 Nursing                                      |                                     | idence                  | 6  ☐Other (Specil<br>ury occurred                 | (y)  |
| DIVISION            | To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune   | Certification:      |                  | 3 Suicide 4 Homicide   | Could not be determined                              | 28e. Place of In<br>building, e   | ic. (Specify        | y)<br>  |                                   |                       |  | City or To                          | iwn, Sta                |   |  |
|                     | To the Hospitel within 24 hours a Within 24 hours a To the Funerel Completely filled   | Medical             |                  |  | Medical Exami  | sician: To the best<br>iner: On the basis of<br>and manner st                     | f examina           |   | vestigation                       | , in my o             |  |                                     | , date ar               |   | o the cause(s)                                   |
|                     | - s ⊢ ō  |                     |                  | >//U   | Mul  | W.T<br>ompleted cause of c  | A death (Item       | 23a) (Type,                                   | Print)                            | P                     | 60515  |                                     | 5                       | /14/08  | )  |
|                     | Sta<br>. Registr   |                     | 31.              | Date filed (Month,   |  | 32. Reset   | 6/4<br>rar's Signa  | iture 2                                       | EG-1/t                            | in                    | In   | M                                   | Sas                     | listery   | MDZ18  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death . 2008 Year Month May **Physician** Elizabeth J. Anthony 10, 6:10A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 206 Vernon Avenue Caroline Federalsburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or For Country) | April 24,1932 | Pennsylvania 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕅 E 214-30-8710 76 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Example 2000. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MYes 2 No Caroline Director Federalsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21632 206 Vernon Avenue United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2X No Specify White 3 ☐Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) J.W. Stowell Elementary/Secondary (0-12) College (1-4or 5+) Proof Reader Printing Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Benjamin Hooper Hackett Stella Bender 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawson H. Anthony/Spouse 206 Vernon Ave., Federalsburg, MD 21632 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Cem. 05/14/08 4 ☐ Donation 5 ☐ Other (Specify) Federalsburg, MD 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licensee 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ecebio disease or condition resulting in death) VASC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence off Examine Fo the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by a should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by

**Physician** 

within 24 hours aries with to the Funeral Director; Aff

Be

70

Certification:

Medical

After this certificate

Division or Vital Records, P.O. Box 68760,

1 ☐ Yes 2 3 Probably 4 Unknown

24a. Was an autopsy performe 1□ Yes 26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Yes 2 ☐ Yes 2

| SPPS.S                                     | Vectic                    |
|--|---------------------------|
| 25. Was case referre examiner? 1 ☐ Yes 2 ☑ |                           |
| 27. Manner of Death                        | 5 ☐ Pending investigation |

3 ☐ Suicide

4 Homicide

5 Pending investigation 6 ☐ Could not be determined

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year)

28b Time of

Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

| 29a. | Certifier  |
|------|------------|
|      | (Check onl |
|      | one)       |

Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Brankle

| 29b. Signature | ind title of certi | fier //      |                   | 20             |               |
|----------------|--------------------|--------------|-------------------|----------------|---------------|
|                | for                | 1/0          |                   | ), O '         |               |
| 30. Name and a | ddress of pers     | on who compl | eted cause of dea | ath (Item 23a) | (Type, Print) |

29d. Date signed (Month, Day, Year) 08

State

31. Oate filed (Month, Day, Year)





Registrar

|   |                   |   | Pleas                              | se Type or Pri                                       |   |   |                      |                                   |                                       | gible.                       |  |  |
|---|-------------------|---|------------------------------------|--|---|---|----------------------|-----------------------------------|---------------------------------------|------------------------------|--|--|
|   | -                 | For<br>State<br>Registrar   |                                    | State of IV  | laryland / De <sub>l</sub><br><i>C</i> o                  | pariment of F<br>ertificate of                                      |                      |                                   | giene<br>Reg. No. 👝 🕜                 | 200                          |  |  |
| LEGIST.   |                   | Decedent's Nan  | ne (First, Middle,                 | Last)  |   |   |                      | 2. Date of Dea                    | ath C                                 | Year                         | 3. Time of Death                                   |  |
| Physicia<br>/Medic  | al .              |   |                                    | ALEXANDER  |   |   |                      | MAY                               |                                       | 2008                         | 1:35PM <sup>™</sup>                                |  |
| Examine   | er                |   |                                    | give street and number                               | )   |   | or Location of Death |                                   | 4c. Cour                              | nty of Death                 | OW   |  |
| Funeral   |                   | 5. Social Security  | Number S                           |  | ge (In yrs. last birthda                                  | y) If Under 1 Year  |                      | 8. Date of Birt                   | h                                     | 9. Birth                     | place (State or Foreign                            |  |
| Director  |                   | 216-70-2  | 2006                               | 1 <b>X</b> M 2□F                                     | <b>70</b> Yrs.  | Months Days   | Hours Min.           | FEB 9,                            | 1938 ENGLAND                          |                              |  |  |
| and<br>ww   | -                 | Usual Residence of<br>10a. State                                  | 10b. County                        |  | 10c. City, Town or  | Location  |                      |                                   |                                       | 1                            | 10d. Inside City Limits                            |  |
| Maryl<br>-f sho<br>fied a   | to                | MD  | TAL                                | вот  |   | EASTON  |                      |                                   |                                       |                              | 1 <b>X</b> ]Yes 2 ☐ No                             |  |
| th the<br>or 28a<br>e noti  | Director          | 10e. Street and Nu  | umber                              |  | 1   | 10f. Zip Code   |                      |                                   | 10g. Citizen of What Country?         |                              |  |  |
| s 23a   |                   |   | WART ST                            |  |   |   | 21601                |                                   | 744.5                                 | USA                          |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral           | <ol> <li>Marital Status</li> <li>Never Mar</li> </ol>             | rried 2 <b>X</b> Marrie            | 12. Was Deceden<br>Armed Forces<br>d 1 ☐ Yes 2 🛣     | l No  | 3. Was Decedent of I<br>If Yes, specify Cub                         |                      | ecify Yes or No-<br>Rican, etc.)  | - 14. H                               | ace - Americ<br>lack, White, |  |  |
| ours a  | gp                | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:              |                                    |  |   | 1 ☐ Yes 2 <b>X</b> No   | Specify:             |                                   | Specify: WHITE                        |                              |  |  |
| "natu   | Completed         | (Spe  | 15. Decedent'<br>ecify only highes | s Education<br>grade completed)                      | ı (Gi   | cedent's Usual Occup<br>ve kind of work done<br>. DO NOT use retire | during most of work  | king                              | 16b. Kind of                          | Business/In                  | dustry   |  |
| withir<br>iene.<br>than   | d wo              | Elementary/Sec<br>12  | ondary (0-12)                      | College (1-4or                                       | 5+)   | MECHANIC  | ·u)                  |                                   | TRUCK                                 | ING CO                       | MPANY  |  |
| e filed<br>al Hyg<br>other<br>vent, i   | Be                | 17. Father's Name   | (First, Middle, L                  | ast)   | I   |   | 18. Mother's Nam     | e (First, Middle,                 | Maiden Surn                           | ame)                         |  |  |
| Ments<br>Ments<br>arked<br>atic e   |                   | DAVID ALEXANDER REBECCA ANN MORRIS                                |                                    |  |   |   |                      |                                   |                                       |                              |  |  |
| 12 sho<br>h and<br>7 is m<br>traum  |                   | 19a. Informant's N  |                                    |  |   | iling Address (Street   |                      |                                   |                                       |                              | Code)  |  |
| Healt<br>Healt<br>tem 2   |                   | 20a. Method of Dis  |                                    | DER/WIFE   | 20b. Place of Dis   | STEWART position (Name of   | 1                    | Date PAR                          | 20c. Location                         |                              | own, State   |  |
| Pages<br>nent of<br>int: If i   |                   |   | Cremation 5 Other (Sp              | 3 □Removal from State ecify)                         | 9   | rematory or other pla   | i i                  | /5/2008                           | STEV                                  | ENSVII                       | LE, MD   |  |
| ermit.<br>epartn<br>nporta<br>ny Inju   |                   | 21. Signature of F  | uneral Service L                   | icensee  |   | 22. Name and Addre  | ess of Facility      |                                   |                                       |                              |  |  |
| 905 8 9   |                   | Joi   | エンド                                | . MERC   |   | 200 S. HA   | RRISON ST            | _EASTON                           | , MD 2                                |                              |  |  |
|   |                   | shock, or he  | art failure. List o                | complications that cause<br>only one cause on each l | ine.  | /   | 7                    |                                   | rest,                                 |                              | Approximate<br>Interval Between<br>Onset and Death |  |
| Physician<br>/Medical   |                   | disease or condition resulting in death)                          | on                                 | a. Due to (or as                                     | s a consequence of):                                      | ung, L  | ancer                |                                   |                                       | -                            | 1 yr. 5mo.   |  |
| Examiner  |                   | Commentally list or   | anditions.                         | b  |   | *   |                      |                                   |                                       |                              |  |  |
| pe sit  | iner              | Sequentially list co<br>if any, leading to in<br>Cause (Disease o | mmediate                           |  | s a consequence of):                                      |   |                      |                                   |                                       |                              |  |  |
| be executed<br>cian and<br>ourial-transit   | ee .              | that initiated event<br>resulting in death)                       | IS I                               | c<br>Due to (or as                                   | s a consequence of):                                      |   |                      |                                   |                                       |                              |  |  |
| e : : : : :   |                   |   | į.                                 | d.   |   |   |                      |                                   |                                       |                              |  |  |
| rtificat<br>ng phy  | Med               | IF FEMALE:  |                                    |  |   |   |                      |                                   |                                       |                              |  |  |
| ath ce  | lan/              | 23b. Was deceder  |                                    |  | 2 ☐ Fetal death 3   | B⊒Ectopic pregnanc  | :y                   |                                   | 23d. Date of delivery  Month Day Year |                              |  |  |
| The law requires that the death certificate bate has been signed by the attending physic bage 2 should be detached for use as the b   | Physician/Medical | 1 □ Yes 2<br>9 □ Unknow   | □No                                | 4⊔Pregnant a<br>9□Unknown                            | at time of death 5  | 5 ☐ Other (specify) _   |                      |                                   |                                       |                              | ,  |  |
| s that<br>ned by  | by Pr             | Part II. Other sign   | ificant condition                  | s contributing to death                              | but not resulting in the                                  | underlying cause giv  | ven in Part I.       | 23e. Did to                       | obacco use co                         | ontribute to t               | he cause of death?                                 |  |
| equire<br>en sig<br>ould b  | o o               |   |                                    |  |   |   |                      | 101                               | ∕es 2∐No                              | 3 ☐ Pro                      | bably 4 Unknown                                    |  |
| 2 8 2   | Completed         |   |                                    |  |   |   |                      | 24a. Was                          |                                       | prior to co                  | opsy findings available                            |  |
| sician: The<br>certificate I<br>rector, page  |                   |   |                                    |  |   |   |                      | perfo<br>1□ Yes                   | rmed?<br>2 No                         | death?<br>1 ☐ Yes            | 2□No   |  |
| siciar<br>s certif  | n                 | 25. Was case refe<br>examiner?<br>1 ☐ Yes 2                       | _                                  | Hospital: 1 ☐ Inpati                                 | ient 2 ☐ ER/Outpati                                       | ent all pos Oth   | 26. Place of Deat    |                                   |                                       | - 6                          |  |  |
| g Phy<br>ler this<br>leral d  | 0                 | 27. Manner of Dea   | ith                                | 28a. Date of Inj<br>(Month, Da                       | ury 28b. Time   | of 28c. Injui   | 4 LI Nursing H       | ome 5X Residence 128d. Describe h |                                       |                              | Ty)  |  |
| endin<br>eath.<br>or: Af<br>he fur  | atio              | 1 Natural 2 Accident  | 5 Pending investiga                | tion   | ay Year) Injury   |   | Yes 2 □ No           |                                   |                                       |                              |  |  |
| or Att<br>after de<br>Direct<br>in by t   | Certification:    | 3□ Suicide<br>4□Homicide  | 6 ☐ Could no<br>determir           | 20e. Place of in                                     | ijury - At home, farm, s<br>tc. <i>(Sp</i> ec <i>ify)</i> | street, factory, office   |                      | 28f. Location (S<br>Cify or Tox   |                                       | mber or Run                  | al Route Number,                                   |  |
| spital<br>nours a<br>nerai<br>/ filled  |                   | 29a. Certifier  | 1 Certifying                       | Physician: To the best                               | t of my knowledge, de                                     | ath occurred at the ti  | ime, date and place  | and due to the                    | cause(s) and                          | manner as s                  | stated.  |  |
| To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page  | Medical           | (Check only one)  | 2 ☐ Medical E                      | xaminer: On the basis and manner s                   |   |   |                      | rred at the time,                 | date and plac                         | e, and due t                 | to the cause(s)                                    |  |
| To t<br>To t  | 2                 | 29b. Signature and  | d title of certifier               | 11 500   |   | 29c. Licens   | se number            | 7                                 | 29d. Date sig                         | ned (Month,                  | Day, Year)   |  |
| <i>C</i> -  | -                 | 30. Name and add  | tress of person "                  | tho completed cause of                               | death (Item 23a) (Tun                                     | e. Print)   | 0100                 | /                                 | 3/                                    | 2/0                          | 18   |  |
| 5   |                   | DAVID SM  | IITH M.D                           | . 8221 TEAL  |   |   | EASTON, M            | D 21601                           |                                       |                              |  |  |
| Stat<br>Registra  | e<br>r            | 31. Date filed (Mor   |                                    |  | rar's Signature   | 5   |                      |                                   |                                       |                              |  |  |
| negistia  |                   | *******   |                                    | mount !  | - 7   |   |                      |                                   |                                       |                              |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Vear MAY /Medical JEAN R. AINSWORTH 2008 1551 4a. Facility Name (If pot institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death EASTON
If Under 1 Year | If Under 24 Hrs. MEMORIAL HOSPITAL EASTON TALBOT 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Days Hours 1 M 2 X 213-22-7268 79 Director MAR 5, MARYLAND 1929 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notifled at Director MD TALBOT EASTON 1 ☐ Yes Mar No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 CURZON COURT 21601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. after 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 X No Completed by Specify illed within 72 hours 3 XWidowed 4 ☐ Divorced WHITE event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 0 CLERICAL BOOKKEEPING MEDICAL Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be if Health and Mental Item 27 is marked or HARRY BRAMBLE RUTH MORRIS 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JENNIFER G. HARRISON/DAUGHTER 22350 HAVERCAMP RD., PRESTON, MD 21655 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If It any Injury or o ō 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SPRING HILL CEMETERY 5/8/2008 EASTON, MARYLAND 21. Signature Funeral Service Licensee 22. Name and Address of Facility Ostnowski C.F.S.P FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PULMOROUTY disease or condition resulting in death) Fibrosi's Years /Medical Due to ras a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 ☐ Unknown Part il. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Tes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 X No 1 Mnpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturai 5 ☐ Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD amely D 66441 05 HOY 2008 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2195 washington Street Easton MD 21601 Kolli Ramem 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State 0 6 2008 Registrar

DHMH 17 Rev 1/2001

AINSWORTH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year GEORGIE LEONE 35 AM APPEL /Medical Mla 15 ,200K 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner THE LIONS CENTER CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🕱 F 212-20-9883 Director 91 5, MAR. 1917 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Items 23a or 28a-f sho ner must be notified at Director MD ALLEGANY CUMBERLAND 1X Yes 2 □ No Maryland 21215-0036 1000 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 516 AVIRETT AVENUE 21502 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ö 1 ☐ Yes 2 No Specify: 2 3 XWidowed 4 ☐ Divorced 'natural", WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 HOME 17. Father's Name (First, Middle, Last) rmit. Pages 1 and 2 should be fili spartment of Health and Mental H portant: If Item 27 Is marked oth ty Injury or other traumatic even Be 18. Mother's Name (First, Middle, Maiden Surname) JOHN BRUCE MCFARLAND FLORA MYRTLE WELSH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JOHN W. APPEL / SON 230 S. MASSACHUSETTS AVE., CUMBERLAND, MD 21502 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or RESTLAWN MEML.GARDENS 05/29/2008 4 Donation 5 Dother (Specify) LAVALE, MD 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, MD 21. Signature of Funeral Servicé Licen e 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CHF Physician Few month disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): the attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ imillation. 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perforn Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of D ath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural
Accident (Month, Day Year) 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number

within 2

State Registrar

31. Date filed (Month

eeu

5 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

46346

29d. Date signed (Month, Day, Year)

Avenue, Cumberland MD 21502

05-15-2008

|                            |   |                | For<br>State<br>Registrar   | State of Marylan  |                                   |                                  | of Death                                       | ivieritai my           | Reg. No  | 2000                          | 3 17041  |
|----------------------------|---|----------------|---|---|-----------------------------------|----------------------------------|--|------------------------|--|-------------------------------|--|
| 100                        | Physici   | an             | Decedent's Name (First, Middle, Last  | )   |                                   |                                  |  | 2. Date of De<br>Month | Da   | y Year                        | 3. Time of Death                                     |
| l k                        | /Medic  |                | Gloria Virginia   |   |                                   |                                  |  |                        | 5/20   |                               | 3:11 a <sub>M</sub>                                  |
|                            | Examir  | er             | 4a. Facility Name (If not institution, give   |   |                                   |                                  | n, or Location of Deat                         | h                      | 40   | . County of Dea               |  |
|                            |   | 734            | Washington Adven 5. Social Security Number 6. Se  |   | last hirthday)                    | Tako:                            | ma Park<br>ear If Under 24 Hrs                 | 8. Date of Bi          | rth  | Montg                         |  |
| 448                        | Funeral<br>Director   |                |   | M 2⊠F 85  | Yrs.                              | Months Da                        |  |                        | ay, Year,  | Gra                           | thplace (State or Foreign<br>ountry)<br>nd Rapids, M |
|                            | land<br>bw<br>It  |                | 10a. State 10b. County  | 10c. Cit  | y, Town or Loc                    | ation                            |  |                        |  |                               | 10d. Inside City Limits                              |
|                            | Mary<br>-f sh   | ţ              | MD Prince G   | eorge's   |                                   | Hva                              | ttsville                                       |                        |  |                               | 1 ⊠Yes 2 No  |
|                            | r 28a   | Director       | 10e. Street and Number  | 20282   |                                   | 10f. Zip Coo                     |  |                        | 10g. Ci  | tizen of What Co              | ountry?  |
|                            | h witl  | a D            | 5823 32nd Avenue  |   |                                   |                                  | 20782  |                        | U.   | S.A.                          |  |
|                            | deat<br>ems   | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U<br>Armed Forces?   | .S. 13. W                         | as Decedent                      | of Hispanic Origin? (S<br>Cuban, Mexican, Puer | Specify Yes or No      |  | 14. Race - Ame<br>Black, Whit |  |
| Maryland 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar must be notified at once. |                | 1 ☐ Never Married 2 ☐ Married<br>3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:                                      |                                   | □Yes 2⊠I                         |  | to thour, etc.,        |  | Specify:                      | White  |
| 5-0                        | 72 hc<br>natu<br>dical  | etec           | 15. Decedent's Edu<br>(Specify only highest grad  |   | i (Give k                         | ent's Usual Oc                   | ne during most of wo                           | rking                  | 16b. K   | (ind of Business              | /Industry  |
| 7                          | ithin<br>ne.<br>e Mec   | Completed by   | Elementary/Secondary (0-12)   | College (1-4or 5+)  | life. D                           | O NOT use re                     | tired)   | J                      |  |                               |  |
| 7                          | led w<br>lygler<br>her th   |                | 12  |   | Finan                             | cial M                           |  | me (First, Middle      |  | vernmen                       | τ  |
| and                        | be fi<br>ntal H<br>od ot  | Be             | 17. Father's Name (First, Middle, Last)   |   |                                   |                                  |  |                        |  | i Surname)                    |  |
| ž                          | d Mel<br>narke  | 2              | Ferguson Fague  19a. Informant's Name/Relationship (7)  | una Brinth  | 10h Mailine                       | Addraga (Ctr                     | Leonor eet and Number or R                     | a Ackma                |  | or Town State                 | Zin Codol  |
| Ma                         | d 2 sl<br>th an<br>7 Is r<br>traur  |                |   |   | 1                                 |                                  | venue, Hya                                     |                        |  |                               |  |
| e,                         | 1 an<br>Heal<br>em 2  |                | Robert J. Brady, S  20a. Method of Disposition  |   | Place of Dispos<br>cemetery, crem |                                  |  | Date                   |  | ocation - City or             |  |
| Baltimore,                 | ages<br>int of<br>t: # II   |                | 1 X Burial 2 ☐ Cremation 3 ☐ F  | temoval from State  |                                   |                                  | 1  | /11//11/00             | A 7  |                               | T7 A   |
| Ė                          | artme   |                | 4 □ Donation 5 □ Other (Specify)  21. Signature of Fune al Service Licens   |   |                                   |                                  | al Cem. 5/                                     | 22/2008                |  |                               | Imore Avenue   |
| B                          | per<br>Dep<br>Imp   |                | 1 Links   | 0   | Gas                               | sch's I                          | Tuneral Ho                                     | me. P.A.               |  |                               | Le, MD 20781   |
|                            | * 3   |                | 23a. P.m. Enter the disease, or comp<br>shock, or heart failure. List only o  | lications that caused the deat  |                                   |                                  |  |                        |  |                               | Approximate<br>Interval Between                      |
|                            | Physician   | 6 4            | Immediate Cause (Final  | a Atheroscle  |                                   |                                  |  |                        |  |                               | Onset and Death                                      |
|                            | /Medical  |                | disease or condition<br>resulting in death)   | Due to (or as a conseq  |                                   | Isease                           |  |                        |  |                               |  |
| 100                        | Examiner  |                |   | Diabetes  |                                   |                                  |  |                        |  |                               |  |
|                            | p #   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseq  | uence of):                        |                                  |  |                        |  |                               |  |
|                            | tificate be executed<br>ig physician and<br>as the burial-transit   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last   | c   |                                   |                                  |  |                        |  |                               |  |
| 90,                        | be execian a  |                |   |   |                                   |                                  |  |                        |  |                               |  |
| 68760,                     | cate b  | edical         |   |   |                                   |                                  |  |                        |  |                               |  |
|                            |   |                | IF FEMALE:  | 23c. If yes, outcome pf pregn   | ancv                              |                                  |  |                        |  | 23d. Date of de               | linton.  |
| Box                        | eath cert<br>attending  | cian           | in the past 12 months?  | 1 ☐ Live birth 2 ☐ Feta<br>4 ☐ Pregnant at time of o                                  | aídeath 3□                        | Ectopic pregna<br>Other (specify |  |                        |  | Month Month                   | Day Year   |
| P.O.                       | the d<br>y the<br>iched   | Physician/N    | 1 □ Yes 2 🖾 No<br>9 □ Unknown   | 9□Unknown   |                                   | ()                               | /  |                        |  |                               |  |
|                            | The law requires that the death cer<br>tte has been signed by the attendir<br>rage 2 should be detached for use   | y Pł           | Part II. Other significant conditions co  | ntributing to death but not res   | ulting in the un                  | derlying cause                   | given in Part I.                               | 23e. Did               | tobacco  | use contribute t              | o the cause of death?                                |
| rds                        | quire:<br>n sign  | d by           |   |   |                                   |                                  |  | 1 🗆                    | Yes 2  | 2 □ No 3 □ P                  | robably 4 🛮 Únknown                                  |
| 000                        | aw re   | Completed      |   |   |                                   |                                  |  | 24a. Was               |  | 24b. Were a                   | utopsy findings available                            |
| ď                          | The lav   | E O            |   |   |                                   |                                  |  | perf                   | opsy<br>ormed?<br>2 N                                    | death?                        | completion of cause of<br>s 2 □ No                   |
| Ita                        | iclan: Th<br>certificate<br>rector, pag   | Be C           | 25. Was case referred to medical examiner?  |   |                                   |                                  | 26. Place of De                                | ath (Check only        |  |                               |  |
| <u>^</u>                   | Physician:<br>this certifical director,   | ToE            | 1 Yes 2 No  | Hospital: 1 ☐ Inpatient 2 🛭   | ER/Outpatient                     | 3□ DOA                           | Other: 4 ☐ Nursing I                           | Home 5□Res             | idence   | 6 □Other (Spe                 | ecify)   |
| n o                        | ng Pl<br>fter t   |                | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury            | 28c. į                           | njury at<br>Work?                              | 28d. Describe          | how inju   | ary occurred                  |  |
| Sio                        | r Attending Physician: ar death. rector: After this certific by the funeral director,   | atic           | 2 ☐ Accident investigation  |   |                                   |                                  | 1 ☐ Yes 2 ☐ No                                 |                        |  |                               |  |
| Division or Vital Records, | tal or Att<br>rs after d<br>al Direct<br>ed in by   | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined   | 28e. Place of injury - At h<br>building, etc. (Speci                                  |                                   |                                  |  |                        | (Street and Number or Rural Route Number,<br>own, State) |                               |  |
|                            | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the funer   | Medical (      |   | sician: To the best of my know<br>iner: On the basis of examina<br>and manner stated. |                                   |                                  |  |                        |  |                               |  |
|                            | To th<br>within<br>To th  | Me             | 29b. Signature and title of cortifier   |   |                                   | 29c. Lic                         | ense number                                    |                        | 29d. Da  | ate signed (Mon               | th, Day, Year)                                       |
|                            | an  |                | Jan Ilm   | m   |                                   |                                  | D48083   |                        | May 8, 2008  |                               |  |
|                            | DE16  |                | 30. Name and address of person who c  |   |                                   | ,                                | 1-1  | - 100 00               |  |                               |  |
|                            | Sta   | to             | Dr. Irving Westne   | y 7600 Carr<br>32. Registrar's Sign   |                                   | enue, l                          | akoma Parl                                     | k, MD 20               | 912  |                               |  |
|                            | Sta<br>Registi  |                | MAY 1 3 2008  | and the state   | and I                             |                                  |  |                        |  |                               |  |
| DH                         | HMH 17 Rev 1/2  | 001            |   |   |                                   |                                  |  |                        |  |                               |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| ded,#19a,  | 1   | For<br>State<br>Registrar FH, 05/2  |   |                                | aryland                                    | •                           |                                   |  | lealth ar<br>Death                            | nd Mer                     | ntal Hy                          | giene<br>Reg. No.                  | 008                     | 17042  |
|--|-----|---|---|--------------------------------|--|-----------------------------|-----------------------------------|--|---|----------------------------|----------------------------------|------------------------------------|-------------------------|--|
| Physician  |     | 1. Decedent's Name (First, Mid  | dle, Last)  |                                | r 22 M                                     |                             |                                   |  |   |                            | Date of Do<br>Month              | eath<br>Day                        | Year<br>1008            | 3. Time of Death 9:27PM M                          |
| /Medical   |     | GRETCHEN L.  la. Facility Name (If not institut   |   |                                |  |                             | 4b. City                          | . Town. o  | r Location of I                               |                            | <u>W1</u>                        |                                    | ty of Death             |  |
| Examiner   |     | WILLIAM HILI  |   | nambor,                        |  |                             |                                   | EAS  | STON  |                            |                                  |                                    | TALBO                   |  |
| Funeral<br>Director  |     | 5. Social Security Number 082–20–7152   | 6. Sex<br>1 □ M 2 🔀 F                                 |                                | ge (In yrs. las<br><b>92</b>               | st birthday)<br>Yrs.        | If Unde<br>Months                 | r 1 Year<br>Days   |   | Min.                       | Date of Bi<br>(Month, D<br>ULY 3 | rth<br>ay, Year)<br><b>0,1915</b>  | Cou                     | nplace (State or Foreign<br>Intry)<br>VYORK        |
| Hygiene. ther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at a Completed by Funeral Director             | -   | Usual Residence of Decedent  10a. State 10b. Coun   | tv  |                                | 10c. City,                                 | Town or Lo                  | cation                            |  |   | . ,                        |                                  |                                    |                         | 10d. Inside City Limits                            |
| fied at  | - 1 | MD  | TALBOT  |                                |  | EASTO                       |                                   |  |   |                            |                                  |                                    |                         | <b>X</b> Yes 2 □ No                                |
| or 28a-f she notified be notified  |     | 10e. Street and Number  |   |                                |  |                             | 10f. Zi                           | p Code   |   |                            |                                  | 10g. Citizen of                    | What Cou                | ıntry?   |
| ust b  |     | 501 DUTCHMAN  | S LANE  |                                |  |                             |                                   |  | 21601   |                            |                                  |                                    | USA                     |  |
| d by Funeral   | 5   | 11. Marital Status  1 □ Never Married 2 ☑ M. 3 □ Widowed 4 □ Divorce  | Armed<br>1 ☐ Ye<br>If Yes,                            | Forces?                        |  | 1                           | Vas Dece<br>f Yes, spe<br>l □ Yes |  | lispanic Origir<br>an, Mexican, I<br>Specify: | n? (Specify<br>Puerto Rica | / Yes or No<br>an, etc.)         | Spec                               | ack, White              | ican Indian,<br>, etc.                             |
| marked other than "hatural", or leans 23a of 28a-1 show imatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director | -   | (Specify only highest grade completed) (Give A  |   |                                |  |                             |                                   | cedent's Usual Occupation ve kind of work done during most of working b. DO NOT use retired) |   |                            |                                  |                                    |                         | ndustry  CATION                                    |
| event, t   |     | 17. Father's Name (First, Middl   |   |                                |  | TIMO                        | the it.                           |  | 18. Mother's                                  | s Name (Fi                 | irst, Middle                     | l<br>e, Maiden Surna               |                         | MILION .   |
| atic e   | 2   |   |   |                                |  |                             |                                   |  |   |                            |                                  | SBACH                              |                         |  |
| יישרו  |     | 19a. Informant's Name/Relatio   |   |                                |  |                             | _                                 |  |   |                            |                                  | •                                  |                         |  |
| rem 27 is marked of other traumatic e  |     | CORNELIUS J. V  | ON BOURGO   | NDII                           |  | BAND<br>ce of Dispo         |                                   |  | ASHING  | CON S'                     |                                  | 20c. Location                      |                         |  |
|  | '   | 1 Burial 2 □ Cremation  |   | m State                        | cen  | netery, cren                | natorý or                         | other plac   | ' i   |                            |                                  |                                    |                         |  |
| njury  |     | 4 □ Donation 5 □ Other  |   |                                | WOOD                                       |                             |                                   |  | PARK 5  | 5/7/2                      | 800                              | EASTO                              | N, M                    | ARYLAND  |
| Important: I<br>any Injury o<br>once.  |     | 21. Signature of Funeral Service  OSeph M.  | Ostrousk'   | C.F                            | 2,50                                       | FE                          | LLOW:                             | S. HI  | ss of Facility ELFENBI<br>RISON               | EIN &                      | NEWN<br>EASTC                    | IAM FUNE<br>N, MD 2                | RAL 1<br>1601           | HOMEPA   |
| sician<br>edical   |     | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of): |   |                                |  |                             |                                   |  |   |                            |                                  |                                    |                         | Approximate<br>Interval Between<br>Onset and Death |
| niner  |     | Asomation - chronic.  |   |                                |  |                             |                                   |  |   |                            |                                  |                                    | 2 non                   |  |
| ne.  | 1 1 | Sequentially list conditions,<br>if any leading to immediate<br>cause. Enter Underlying   | b. Due t  | to (or an                      | การสมเต                                    | neu ofi                     |                                   |  |   | 1                          |                                  | C 2-                               |                         | _  |
| ial-transit  Examin  |     | Cause (Disease or injury that initiated events resulting in death) Last   | voveular Heer   |                                |  |                             |                                   | enf  |   | 2 years                    |                                  |                                    |                         |  |
| the bur  |     |   | nce of):  |                                |  |                             |                                   |  |   |                            |                                  |                                    |                         |  |
| for use as   |     | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 ☑ No<br>9 □ Unknown   | 1 ☐Liv  | e birth<br>egnant a            | e pf pregnand<br>2 □ Fetal dat time of dea | eath 3                      | Ectopic p                         |  | /   |                            |                                  |                                    | ate of deli             | very<br>Day Year                                   |
| <u>ه</u> ه   | '   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause   |   |                                |  |                             |                                   |  | en in Part I,                                 |                            |                                  |                                    |                         | the cause of death?                                |
| page 2 should be completed by  | -   | 7190  | pecho   | Park                           | Po al                                      | 0                           | 2-                                |  |   |                            |                                  | Yes 2☐µNo                          |                         | bbably 4 ☐Unknowr                                  |
| ector, page 2 should   | -   | 179   | Fr Cho  | J-4-5-1                        |  | · · · ·                     |                                   |  |   | _                          | 24a. Was<br>auto<br>perf         | s an 24b<br>opsy<br>ormed?         | death?                  | topsy findings available<br>ompletion of cause of  |
| 8 S  |     | 25. Was case referred to media  | men 11a   |                                |  |                             |                                   |  |   |                            | 1∐ Yes                           | 2 1 No                             | 1 ☐ Yes                 | 2 □ No   |
|  |     | examiner?  1 Yes 2 No   | Hospital:   | □Inpatie                       | ost 2005                                   | R/Outpatien                 | 3 🗍 De                            | Oth  | er: Place of                                  |                            |                                  |                                    |                         |  |
| eral din   | 1   | 27. Manner of Death   | 28a. Da   | te of Inju                     | ury 2                                      | 8b. Time of                 |                                   | 28c. Injur<br>Wor  | 4 L <b>19</b> 4 VUIS                          |                            |                                  | idence 6 🗆 O                       |                         | eify)  |
| e fun  |     | 1 Natural 5 Pend<br>2 Accident inves  | ling (Mi<br>tigation                                  | onth, Da                       | ay Year)                                   | Injury                      | м                                 |  | k?<br>Yes 2∐No                                | ,                          |                                  |                                    |                         |  |
| led in by the funeral  |     | 3 Suicide 6 Coul<br>4 Homicide dete   | d not be<br>mined 28e. Pla<br>bui                     | ce of inj<br>ilding, et        | jury - At homo<br>tc. <i>(Specify)</i>     | e, farm, stre               | et, factor                        | y, office  |   | 28f.                       | Location<br>City or To           | (Street and Nun<br>wn, State)      | nber or Ru              | ral Route Number,                                  |
| ely fill   |     | 29a. Certifier 1 ☐ Certify (Check only one) 2 ☐ Medic   | ring Physician: To t<br>al Examiner: On the<br>and ma | he best<br>basis o<br>anner st | of examinatio                              | edge, death<br>n and/or inv | occurred                          | at the tir   | me, date and<br>opinion, death                | place, and<br>occurred     | due to the                       | cause(s) and r<br>, date and place | nanner as<br>e, and due | stated.<br>to the cause(s)                         |
| complet  | 1   | 29b. Signature and title of certif  | ier   |                                |  |                             |                                   |  | e number                                      |                            |                                  | 29d. Date sign                     |                         |  |
|  |     | Muse  | ee a-s  | cli                            | lej  |                             |                                   | M4.  | 1587  | in                         | B                                | 05-                                | 05-                     | 2008   |
|  |     | Russell of  | Schilly   | 80                             | death ftem 2                               | 3a) (Type, I                | rint)                             | ver  | V Dr  | Eas                        | ton                              | 05-1                               | 2160                    | )(   |
| State<br>Registrar   | Ì   | 31. Date filed (Month, Day, Yea MAY 0 6 2   |   |                                | rar's Signatur                             | Sugar                       |                                   |  |   |                            |                                  |                                    |                         |  |

DHMH 17 Rev 1/2001

the death certificate be executed Box 68760, Ö مَ Division or Vital Records, or Attending Hospital

Maryland 2121

Baltimore,

AVEI

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 219 S. WASHINGTON ST., EASTON, MD 21601 DENNIS DESHIELDS M.D.

31. Date filed (Month, Day, Year) State 02 MAY Registrar

29b. Signature and title of certifier

29a. Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1)005

29c. License number

29d. Date signed (Month. Dav. Year)

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

1. Decedent's Name (First, Middle, Last) Year **Physician** JUNE DOWLER BUTEAU MAY 8 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY NATIONAL NAVAL MEDICAL CENTER BETHESDA Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 M 2 K F June 3, 550-22-6142 1922 California 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If them 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County Director Maryland | Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20816 U.S.A. 5209 Wyoming Road by Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Writer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be May Rehfeld Albert Francis Dowler ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5209 Wyoming Road Bethesda, Maryland 20816 Bernard L. Buteau / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat'l Cem. 6-12-08 Arlington, Va. 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses

**Physician** /Medical Examine

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760.

27

|                   | Immediate Cause (Final disease or condition resulting in death)                                 | a. UREMIA  |                              |
|-------------------|---|--|------------------------------|
|                   | resulting in death)   | Due to (or as a consequence of):   |                              |
| ē.                | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying              | b. Due to (or as a consequence of):  |                              |
| Examiner          | cause. Enter Underlying Cause (Disease or figury that initiated events resulting in death) Last | c  | _                            |
|                   | •   | d  |                              |
| Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown          | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) |                              |
| by                | Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobac               |
| Completed         |   |  | 24a. Was an autopsy performe |
| BeC               | 25. Was case referred to medical examiner?  | 26. Place of Deat  | h Check onl one              |
| 8                 | 1 ☐ Yes 2 ☐ No  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho  | me 5 🗆 Residend              |

W

29a. Certifier

| er |                  |
|----|------------------|
|    | al Examiner      |
| ļ  | hysician/Medical |
|    | by Physicia      |
|    | ompleted         |
|    | : To Be Comp     |
|    | Certification    |

| Š, | Was case referre examiner? | d to medical |
|----|----------------------------|--------------|
|    | 1 ☐ Yes 2 🔀 N              | 0            |
|    | Manner of Death            | 150          |
|    | 1 X Natural                | 5   Pendin   |

Pending investigation 2 Accident 6 Could not be

3 Suicide 4 Homicide

29b. Signature and title of certifie

1 🔀 Inpatient 28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

2 ER/Outpatient 3 DOA 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

5130 Wisconsin Ave. N.W. Washington DC 20016

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 0101240594 (VA)

8ەە2

29d. Date signed (Month, Day, Year)

23d. Date of delivery

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

Month

23e. Did tobacco use contribute to the cause of death?

12:40 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 XYes 2 No

ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add MC USN **BYERS** LT

NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600

28d. Describe how injury occurred

24a. Was an autopsy performe 1□ Yes 2☑ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

State Registrar





20

|                                |   |                     | 1- State of Maryland / Depa<br>Registrar Cert  | tificate of Death  | Reg. N                                      | 2000 17011  |  |  |  |  |  |
|--------------------------------|---|---------------------|--|--|---|---|--|--|--|--|--|
|                                | Physicia  | an                  | 1. Decedent's Name (First, Middle, Last) Aurelia Watson Brown  |  | Month 7,                                    | ay 2008 3. Time of Death 7:30A. M   |  |  |  |  |  |
| ,                              | /Medic<br>Examin  | al                  | 4a. Facility Name (If not institution, give street and number) 3128 Gracefield Road, HS#219  | 4b. City, Town, or Location of Death Silver Spring   | 4   | c. County of Death<br>Montgomery  |  |  |  |  |  |
|                                | Funeral   |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  |  | Date of Birth                               | 9. Birthplace (State or Foreign   |  |  |  |  |  |
|                                | Director  |                     | 578-86-2101  |  | Apr.10,1                                    | .921   South Carolina   |  |  |  |  |  |
|                                | Aaryland<br>f show<br>ed at   | or                  | Maryland Montgomery Silver Sp  |  |   | 10d. Inside City Limits 1 □ Yes 2 ▼No                                     |  |  |  |  |  |
|                                | with the Page or 28a-<br>t be notifi  | Direct              | 10e. Street and Number<br>3128 Gracefield Road, HS#219   | 10f. Zip Code<br>20904   | _   | Citizen of What Country?  |  |  |  |  |  |
| 030                            | be filed within 72 hours after death with the Maryland that Hyglene.  did other than "natural", or tems 23a or 28a-f show event, the Medical Eximiner must be notified at       | by Funeral Director | 1 TV00 2M NO   | Vas Decedent of Hispanic Origin? (Speci<br>Yes, specify Cuban, Mexican, Puerto Ri<br>☐ Yes 2 No Specify: | fy Yes or No-<br>ican, etc.)                | 14. Race - American Indian, Black, White, etc. Specify: White             |  |  |  |  |  |
| 2                              | n 72 hor<br>r "natura<br>ledical E  | Completed           | (Specify only highest grade completed) (Give life. D   | ent's Usual Occupation<br>kind of work done during most of working<br>OO NOT use retired)                | 7   | Kind of Business/Industry   |  |  |  |  |  |
| 717                            | filed withi<br>Hygiene.<br>other thar<br>ent, the M   | Comp                |  | ral Support  18. Mother's Name (   |   | rth Presbyterian Church   |  |  |  |  |  |
| _                              | 0 = 0 %   | To Be               | 17. Father's Name (First, Middle, Last)  Joseph Calhoun Watson   | Aurelia C  | unningham                                   |   |  |  |  |  |  |
| Mary                           | nd 2 sho<br>Ith and It<br>27 is ma<br>r trauma  |                     | 1 12   | g Address (Street and Number or Rural<br>Gracefield Road, HS   |   | y or Town, State, Zip Code) 7er Spring, Md.20904                          |  |  |  |  |  |
| Baitimore, Maryland 21215-0036 | permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic enonce.  |                     | 4 Donation 5 Other (Specify)   | sition (Name of natory or other place) tan Crematory 5/7/  |   | Location - City or Town, State  |  |  |  |  |  |
| Balt                           | permit. Departr Importa any Inju  |                     | 21. Signature of Funeral Service Licensee  A gradel V B and world  4   | ohala ViesBórgwardt<br>400 Powder Mill Ro  | Funeral<br>ad Beltsv                        | Home, Pa<br>ville, Maryland20705  |  |  |  |  |  |
|                                | Physician<br>/Medical   | 9 2                 | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.   |  | respiratory arrest,                         | Approximate<br>Interval Between<br>Onset and Death                        |  |  |  |  |  |
|                                | Examiner  | L                   |  |  |   |   |  |  |  |  |  |
|                                | outed<br>d<br>ansi  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of): |  |   |   |  |  |  |  |  |
| 68760,                         | ficate be executed<br>physician and<br>is the burial-transi   | sal Ex              | resulting in death) Last  Due to (or as a consequence of):   | quence of):  |   |   |  |  |  |  |  |
| _                              |   | Medical             | IF FEMALE: 23c. If yes, outcome pf pregnancy   |  |   | 23d. Date of delivery   |  |  |  |  |  |
| P.O. Box                       | w requires that the death certif<br>been signed by the attending<br>should be detached for use a  | Physician/M         | 23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown  | □Ectopic pregnancy □ Other (specify)   |   | Month Day Year  |  |  |  |  |  |
|                                | luires that<br>signed by  | by                  | Hypertension: Osteoporosis   | nderlying cause given in Part I.   | 23e. Did tobaco                             | co use contribute to the cause of death?  2 ※ No 3 □ Probably 4 □ Unknown |  |  |  |  |  |
| Division or Vital Records,     | 2 88 2  | Completed           |  |  | 24a. Was an autopsy performed               |   |  |  |  |  |  |
| Vita                           | Physician: Th<br>r this certificate<br>ral director, pag  | Be                  | 25. Was case referred to medical examiner?   | 26. Place of Death   |   | e 6 □Other (Specify)  |  |  |  |  |  |
| on or                          | ding Phy<br>I.<br>After this<br>funeral d   | ion: To             | 20 Date of Injury 20th Time of   |  | 28d. Describe how i                         |   |  |  |  |  |  |
| )ivisi                         | or Attending<br>after death.<br>Director: After<br>in by the fune   | Certification:      | 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined   28e. Place of injury - At home, farm, st building, etc. (Specify)  | reet, factory, office 2  | 28f. Location (Stree<br>City or Town, S     | t and Number or Rural Route Number,<br>tate)                              |  |  |  |  |  |
| _                              | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director. After this certificate ha completely filled in by the funeral director, page | edical Ce           |  | th occurred at the time, date and place, and execution, in my opinion, death occurred.                   | and due to the caus<br>ed at the time, date | se(s) and manner as stated.<br>and place, and due to the cause(s)         |  |  |  |  |  |
|                                | <b>To th</b> e within 2 <b>To the</b> соттрle   | Mec                 | 29b. Signature and title of continer   | 29c. License number  | i   | Date signed (Month, Day, Year)  |  |  |  |  |  |
|                                | 8   |                     | Aday Julicher M)   | D23649   | Ma  | ay 7, 2008  |  |  |  |  |  |
|                                |   |                     | 30. Name and add as of person who completed cause of reath (Item 23a) (Type, John H. Stuckey, M.D. 3110 Gracefield   | d Road Silver Sprin  | ng, Məryla                                  | and 20904   |  |  |  |  |  |
|                                | St<br>Regis   | tate<br>trar        | 31. Date filed (Month Ray Yaar) 2 2008 32. Signature   | perti  |   |   |  |  |  |  |  |

|                                |  |                | _ For  | State of Ma                               | aryland / Dep                       |  |  | Mental Hyg            | jiene                                     |  |  |  |  |
|--------------------------------|--|----------------|--|---|-------------------------------------|--|--|-----------------------|---|--|--|--|--|
|                                |  |                | State Registrar  |   | Ce                                  | rtificate of   | Death                                      | R                     | eg. No. 2                                 | 17046  |  |  |  |
|                                | Obvolet  |                | 1. Decedent's Name (First, Middle, Last)   |   |                                     |  |  | Date of Dea     Month | th Day Year                               | 3. Time of Death                                   |  |  |  |
|                                | Physicia<br>/Medic   |                | Sylvia R.  | Breesl                                    | kin                                 |  |  | May                   | 8, 2008                                   | 15:08 ™  |  |  |  |
|                                | Examin   |                | 4a. Facility Name (If not institution, give s  |   |                                     |  | or Location of Death                       | n                     | 4c. County of Death                       |  |  |  |  |
| V:                             | 3  |                | Holy Cross Hos   | •   |                                     |  | er Spring                                  | T-0                   | Montgor                                   |  |  |  |  |
|                                | Funeral  |                | 5. Social Security Number 6. Sex   | M 2 F 7. Ag                               | e (In yrs. last birthday<br>QQ Yrs. | Months Days  | If Under 24 Hrs.<br>Hours Min.             | (Month, Day           | , Year) C                                 | thplace (State or Foreign ountry)                  |  |  |  |
|                                | Director   |                | 579-16-0956  | X   | 88 Yrs.                             |  |  | April                 | 4, 1920 Was                               | sn. D. C.  |  |  |  |
|                                | land<br>ow   |                | 10a. State 10b. County   |   | 10c. City, Town or L                | ocation  |  |                       |   | 10d. Inside City Limits                            |  |  |  |
|                                | Mary<br>-f sh  | to             | Maryland Montgome  | rv  | Silver S                            | nring  |  |                       | 1 Yes 2 □                                 |  |  |  |  |
|                                | r 28a  | Directo        | 10e. Street and Number   |   | ,                                   | 10f. Zip Code  |  | 1                     | 10g. Citizen of What C                    | ountry?  |  |  |  |
|                                | h with   | a D            | 9511 Saybrook Aven   | ue  |                                     | 2090   | )1   |                       | U. S. A                                   | •  |  |  |  |
|                                | deat   | Funeral        |  | 2 Was Decedent                            | Ever in U.S. 13.                    | Was Decedent of  | Hispanic Origin? (S<br>can, Mexican, Puerl | pecify Yes or No-     | 14. Race - Ame<br>Black, Whi              |  |  |  |  |
| စ္                             | after<br>or ite<br>mine  |                | 1 ☐ Never Married 2 ☐ Married  | Armed Forces?  1  Yes 2 1  If Yes, Give   | No                                  | 1 ☐ Yes 2 No   |  | ,                     |   | White  |  |  |  |
| 9                              | ours<br>tral",<br>Exa  | d by           | 3 X Widowed 4 □ Divorced   | Year or Dates:                            |                                     |  |  |                       |   |  |  |  |  |
| 2                              | "natu  | Completed      | 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)                       | (Giv                                | edent's Usual Occu<br>e kind of work done<br>DO NOT use retire | durina most of wor                         | rking                 | 16b. Kind of Business                     | /Industry  |  |  |  |
| 121                            | within<br>ene.<br>than   | m<br>d         | Elementary/Secondary (0-12)  | College (1-4or 5                          | 5+) _                               | etary  | <i>50)</i>                                 |                       | Dept. of A                                | rmy  |  |  |  |
| 2                              | filed within 72 hours after death with the Maryland<br>Hygiene.<br>When than "natural", or items 23a or 28a-f show<br>ther than "natural", or items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at   |                | 17. Father's Name (First, Middle, Last)  |   | 1 3                                 |  | 18. Mother's Nar                           |                       | Maiden Surname)                           |  |  |  |  |
| an                             | d be   | o Be           | Nathan Raine   |   |                                     |  | Esthe                                      | r Gendas              | on  |  |  |  |  |
| $\overline{\Sigma}$            | shoul<br>nd Me<br>mark<br>imati  | 욘              | 19a. Informant's Name/Relationship (Typ  | ne. Print)                                | 19b. Mail                           | ing Address (Stree   | t and Number or Ru                         | ural Route Numbe      | r, City or Town, State,                   | Zip Code)  |  |  |  |
| S                              | nd 2<br>alth a<br>27 is<br>r trau  |                | Robin E. Levien -  | Daughter                                  | 6008                                | Avon Dr  | ive, Beth                                  | esda, Ma              | ryland 20                                 | 814  |  |  |  |
| ē,                             | s 1 a<br>of Hea<br>Item  |                | 20a. Method of Disposition   |   | 20b. Place of Disp                  | osition (Name of<br>ematory or other pla                       | ace)                                       | Date                  | 20c. Location - City o                    | r Town, State                                      |  |  |  |
| Ë                              | Page<br>net: If  | 1              | 1 ☐ Furial 2 ☐ Cremation 3 ☐ Re<br>4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State                         | Mount Le                            | banon Cer  | n. 5/12                                    | /2008                 | Adelphi,                                  | Maryland   |  |  |  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healin and Mental Hygiene. Inportment of Healin and Mental Hygiene. Inportant: If Item 27 is marked other than "natural", or items 23a or 28a-4 show any Injury or other traumatic event, the Medical Examiner must be notifiled at once. |                | 21. Signature of Funeral Service License   | e 🖊                                       |                                     |  |  |                       | tion, Inc.<br>ille, Mary                  |  |  |  |  |
| m<br>—                         | 8 2 E 8 8  | .1 10          | Donald .   | Stottle                                   | emyer 1                             | 091 Rock   | ville Pik                                  | e, Rockv              | ille, Mary                                |  |  |  |  |
| П                              |  |                | 23a. Part1. Enter the disease, or complications, or heart failure. List only on                              | cations that caused<br>e cause on each li | the death. Do not ea<br>ne.         | nter the mode of dy  | ring, such as cardia                       | c or respiratory ar   | rest,                                     | Approximate<br>Interval Between<br>Onset and Death |  |  |  |
| 9                              | Physician  |                | Immediate Cause (Final disease or condition  | Aor                                       | tic Stenos                          | is   |  |                       |   | Onset and Beam                                     |  |  |  |
|                                | /Medical<br>Examiner   |                | resulting in death) ;  | Due to (or as                             | a consequence of):                  |  |  |                       |   |  |  |  |  |
|                                | LXummer  | <u></u>        | Sequentially list conditions, b  | . Due to (or se                           | a consequence of):                  |  |  |                       |   |  |  |  |  |
|                                | ted<br>nsit  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) |   |                                     |  |  |                       |   |  |  |  |  |
|                                | execu<br>n and<br>al-tra   | xar            | that initiated events c<br>resulting in death) Last  | G.  |                                     |  |  |                       |   |  |  |  |  |
| 8760                           | cate be executed oblysician and the burial-transit   | dical E        | d  |   |                                     |  |  |                       |   |  |  |  |  |
| ပ                              | ificate<br>g phy<br>as the   | edic           |  |   |                                     |  |  |                       |   |  |  |  |  |
| Вох                            | death certific<br>e attending p<br>id for use as i   | M/N            | IF FEMALE:<br>23b. Was decedent pregnant   | 3c. If yes, outcome                       |                                     | □Ectopic pregnan   | 01/  |                       | 23d. Date of de                           | ,  |  |  |  |
| _*                             | 0 0 0  | icia           | in the past 12 months?<br>1 □ Yes 2 <b>X</b> No  | 4□Pregnant a                              |                                     | Other (specify)  |  |                       | Month                                     | Day Year   |  |  |  |
| o.                             | at the<br>by th<br>tache   | Physician/Me   | 9 ☐ Unknown  |   |                                     |  |  |                       |   |  |  |  |  |
| Records, P.                    | The law requires that the do   | by F           | Part II. Other significant conditions con  | tributing to death b                      | ut not resulting in the             | underlying cause g   | iven in Part I.                            |                       | obacco use contribute<br>⁄es 2□No 3□F     | **   |  |  |  |
| ord                            | requil   | ted            |  |   |                                     |  |  | ' ' '                 |   | , –  |  |  |  |
| e<br>G                         | E SS   | ple            |  |   |                                     |  |  | 24a. Was a<br>autop   | an 24b. Were a                            | autopsy findings available completion of cause of  |  |  |  |
| _                              |  | Completed      |  |   |                                     |  |  |                       | rmed? death?<br>X□No 1 □ Ye               | s 2□No   |  |  |  |
| Vita                           | stclan: Th<br>certificate<br>rector, pag   | Be             | 25. Was case referred to medical examiner?   | lospital:                                 |                                     | lo   | thor                                       | ath (Check only or    |   |  |  |  |  |
| or                             | Phys<br>this<br>al dir   | To             | 1 ☐ Yes 2 ☐XNo   | lospital: 1 XInpatio                      |                                     | SIR SLIDOA   | 4 LI Nursing F                             | T                     | dence 6 ☐Other (Sp<br>now injury occurred | ecify)   |  |  |  |
| CO                             | ding F   | ion            | 1 XNatural 5 ☐ Pending   | (Month, Da                                |                                     | W  | ork?<br>□Yes 2□No                          | 200. Describe i       | low injury occurred                       |  |  |  |  |
| Division or                    | or Attending Physician:<br>after death.<br>Director: After this certifica<br>in by the funeral director, in  | fical          | 3 Suicide 6 Could not be   | 28e. Place of inj                         | ury - At home, farm, s              |  |  |                       | Street and Number or F                    | Rural Route Number,                                |  |  |  |
|                                | pltal or Al  | Certification: | 4 ☐ Homicide determined  | building, et                              | c. (Specify)                        |  |  | City or Tow           | vn, State)                                |  |  |  |  |
|                                | Hospita<br>4 hours<br>Funeral<br>tely filled   |                |  |   |                                     |  |  |                       | cause(s) and manner                       |  |  |  |  |
|                                | To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b  | Medical        | (Check only 2 Medical Examination)   | and manner st                             |                                     |  |  | T                     | date and place, and d                     |  |  |  |  |
|                                | To the within 2 To the comple  | Σ              | 29b. Signature and title of certifier  | 1111                                      | 100                                 |  | nse number                                 |                       | 29d. Date signed (Moi<br>May 8, 20        |  |  |  |  |
|                                | 13   |                | 1 Want   | 11100                                     | 10/                                 |  | 3376                                       |                       | ray 0, 20                                 |  |  |  |  |
|                                |  |                | 30. Name and address of person who co  |   | death (Item 23a) (Type<br>Research  | e, Print)  | l. Rockwi                                  | lle Mars              | v1and 208                                 | 50   |  |  |  |
|                                |  |                | Rachel Vile, M.  |   | rar's Signature                     | Donterate  | , KUCKVI.                                  | TIC, Hal              | y Land 200.                               |  |  |  |  |
|                                | Sta<br>Begisti   |                | 31. Date filed (Month, Day, Year)  | 2008                                      | Signature                           | Brasky)  |  |                       |   |  |  |  |  |

DHMH 17 Rev 1/2001

|                     |  |  | 1 - For<br>State<br>Registrar   | State                                      | of Ma      | ryland /                    |  | artment of H<br>rtificate of I                |                              | and M                    |                                       | iene                       | 0.8                           | 17047                               |
|---------------------|--|--|---|--|------------|-----------------------------|--|---|------------------------------|--------------------------|---------------------------------------|----------------------------|-------------------------------|-------------------------------------|
|                     | Physici  | 20   | 1. Decedent's Name (First, Midd   |  | Ε.         |                             |  |   |                              |                          | 2. Date of Death<br>Month             | Dav                        | Year                          | 3. Time of Death                    |
|                     | /Medic   |  | Catherine   |  |            | Blundell                    |  |   |                              | May 2, 2                 | 2008                                  |                            | 12:18 PM                      |                                     |
|                     | Examin   | er   | 4a. Facility Name (If not institutio  |  |            | h (1-)                      |  | 4b. City, Town, or                            |                              | of Death                 |                                       |                            | nty of Death                  |                                     |
|                     | Francis  |  | Allegany Co. N 5. Social Security Number  | ursing &                                   |            | ID. Ce                      |  | If Under 1 Year                               |                              | 24 Hrs.                  | 8. Date of Birth                      |                            | Allega<br>9. Birtho           | ny<br>place (State or Foreign       |
|                     | Funeral<br>Director  |  | 114-24-4190   | 1□M 2∭F                                    | 1          | 86                          | Yrs.   | Months Days                                   | Hours                        | Min.                     | 8. Date of Birth (Month, Day, 07/03/1 | <sub>Year)</sub><br>921    | Cour                          | ntry)                               |
|                     | pu »   |  | Usual Residence of Decedent  10a. State 10b. County                               |  |            | 10c. City, To               | our or Lo  | antion  |                              | `                        |                                       |                            |                               | 0d. Inside City Limits              |
|                     | within 72 hours after death with the Maryland<br>ene.<br>then "natursi", or items 23e or 28e-1 show<br>the Medical Exercities transities and   | ō  | MD 100. County  | Allegany                                   |            | Too. Oily, 11               |  |   | ام                           |                          |                                       |                            | - 1.                          | 1 X Yes 2 □ No                      |
|                     | the N  | Director   | 10e. Street and Number  | Allegany                                   |            |                             |  | Cumberlar<br>10f. Zip Code                    | ıa                           |                          | 10                                    | Da. Citizen o              | of What Cour                  | ntry?                               |
|                     | h with   |  | 730 Furnace   | Street                                     |            |                             |  |   | 2150                         | 02                       |                                       |                            | USA                           | ,                                   |
|                     | death  | neral  | 11. Marital Status  | 12. Was Dec                                | cedent E   | ver in U.S.                 | 13.  | Was Decedent of Hi<br>f Yes, specify Cuba     | ispanic Orig                 | gin? (Spe                | cify Yes or No-                       |                            | ace - Americ                  |                                     |
| 36                  | or its   | by Fun   | 1 ☐ Never Married 2 ☐ Mar   | ned 1 ☐ Yes<br>If Yes, G                   | 2 (XN      | 0                           |  | 1 Tes, specify Cuba<br>1 ☐ Yes 2 🖾 No         |                              | i, rueno r               | noan, etc.)                           | Spec                       | llack, White,                 |                                     |
| Ö                   | hours  | q pa   | 3 🔀 Widowed 4 □ Divorced  | Year or I                                  | Dates:     | 1/1                         | 6a Deco  | fant's Heuri Ossus                            | ation                        |                          |                                       |                            | Business/In-                  | Vhite                               |
| 15                  | nin 72<br>n na   | Completed  | (Specify only highe   | st grade completed,                        | completed) |                             | 16a. Decedent's Usual Occupation (Give kind of work done during most during most |   |                              | t of workin              | ng                                    | iob. Kind oi               | Dusiness/m                    | dustry                              |
| 212                 | d with<br>giene  | mo   | Elementary/Secondary (0-12)   | College<br>5                               | (1-40r 5   | +)                          |  | Nurse   |                              |                          |                                       | Med                        | ical                          |                                     |
| pu                  | be file<br>tal Hy<br>d oth   | Be (   | 17. Father's Name (First, Middle,   |  |            |                             |  |   |                              |                          | (First, Middle, M                     |                            | ame)                          |                                     |
| yla                 | ould I<br>Ment   | To   | Arthur  | W.   |            | Lyma                        |  |   |                              | herir                    |                                       | Ε.                         |                               | Garland                             |
| Maryland 21215-0036 | d 2 sh<br>th and<br>7 is n<br>traun  |  | 19a. Informant's Name/Relations<br>Charles J. Blut                                |  | on         | 1                           |  | g Address <i>(Street a</i><br>National        |                              |                          |                                       |                            |                               |                                     |
|                     | Heall<br>Heall<br>tem 2  |  | 20a. Method of Disposition  |  |            | 20b. Place                  | of Dispo   | sition (Name of                               |                              |                          |                                       |                            | n - City or To                |                                     |
| OE I                | Pages<br>ent of<br>nt: If I  |  | 1 Burial 2 □ Cremation  4 □ Donation 5 □ Other (5                                 |  | State      | 1                           | -  | natory`or other plac<br>s Luth. C             |                              | )5/08                    | /2008                                 | Pine                       | Grove                         | РΔ                                  |
| Baltimore,          | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural; or itams 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the notified an once. |  | 21. Signature of Funeral Service  |  |            |                             | 22   | . Name and Addres                             | s of Facilit                 | y Ada                    | ms Fami:                              | ly Fur                     | neral                         | Home, P.A.                          |
|                     | 40264  |  | 23a. Part 1. Enter the disease, o   | complications that                         | Caused     | the death D                 |  | 04 Decatu                                     |                              |                          |                                       |                            | MD Z                          | 1502<br>Approximate                 |
|                     |  |  | shock, or heart failure. List<br>Immediate Cause (Final                           | only one cause on                          | each lin   | Θ.                          |  | la tz   | a at                         |                          | respiratory and                       | 31,                        |                               | Interval Between<br>Onset and Death |
|                     | Pnysician<br>/Medical  |  | disease or condition resulting in death)  | d  |            | consequence                 | _  | ea na   |                              |                          |                                       |                            | 2                             | Moulh                               |
| п                   | Examiner   |  | Sequentially list conditions  | h =  |            | ·                           |  |   |                              |                          |                                       |                            |                               |                                     |
|                     | sit ad   | Iner   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin | consequenc                                 | ce of):    |                             |  |   |                              |                          |                                       |                            |                               |                                     |
| _                   | and I-trans  | xam  | Cause (Disease or injury that initiated events resulting in death) Last C         |  |            |                             |  |   |                              |                          |                                       |                            |                               |                                     |
| 8760,               | certificate be executed nding physician and use as the burial-transit  | dical Examiner   | d   |  |            |                             |  |   |                              |                          |                                       |                            |                               |                                     |
| 9                   | uficate<br>g phy:<br>as the  |  |   | d  |            |                             |  |   |                              |                          |                                       |                            |                               |                                     |
| Вох                 | leath certific<br>attending p  | an/N   | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, ou                            |            | of pregnancy<br>2 Petal dea | ath 3.⊡  | Ectopic pregnancy                             |                              |                          |                                       |                            | Date of delive                | *                                   |
| O. B                | 0 0 0  | Physician/Me   | in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown                                 |  | nant at    | time of death               |  | Other (specify)                               |                              |                          |                                       | '                          | Month                         | Day Year                            |
| Р.                  | that the died by the detached  | Phy  | Part II <sub>n</sub> Other significant conditi                                    | ens contributing to c                      | death bu   | t not resulting             | a in the ur  | ndertving cause give                          | an in Part I                 |                          | 23e Did tob                           | acco use co                | ontribute to th               | ne cause of death?                  |
| ds,                 | The law requires that the te has been signed by thoage 2 should be detache   | Completed by   | Chun'c Obs  | nutive                                     | Tul        |                             | (A)  | scare   |                              |                          |                                       | s 2 🗀 No                   |                               |                                     |
| of Vital Record     | s beer   | olete  |   |  |            | J                           |  |   |                              |                          | 24a. Was an                           | 1 24                       | o. Were auto                  | psy findings available              |
| Re                  | The lav  | E  |   |  |            |                             |  |   |                              |                          | autopsy<br>perform                    | led?                       | prior to condeath?  1  Yes    | mpletion of cause of                |
| ital                |  | BeC  | 25. Was case referred to medica   |  |            |                             |  |   | 26. Place                    | of Death                 | (Check only one                       |                            | 1 1 1 1 0 3                   |                                     |
| × ×                 | d is   | 2  | examiner?<br>1 Tes 2 No   | Hospital: 1 🗆                              | Inpatier   | nt 2 ER/                    | Outpatien  | t 3 DOA Othe                                  | al Nu                        | rsing Hom                | ne 5 Reside                           | nce 6 🗆 C                  | ther (Specifi                 | (y)                                 |
|                     | ling P   | iuo]   | 27. Manner of Death  1 Natural 5 ☐ Pendir   | ig .                                       | of Injur   | Year) 28t                   | o. Time of<br>Injury   | Work  | ι?                           |                          | 8d. Describe ho                       | w injury occ               | urred                         |                                     |
| Division            | il or Attending<br>after death.<br>Director: After<br>d in by the fune   | flcat  | 2 Accident investi<br>3 Suicide 6 Could   | not be                                     | e of Iniu  | ry - At home                | farm stre  | M 1 1   | Yes 2□1                      | _                        | 8f. Location (Str                     | eet and Nu                 | mber or Rura                  | al Route Number                     |
| <u>≤</u>            | al or A<br>s after<br>it Dire  | Certification:   | 4 Homicide determ   | build                                      | ling, etc  | (Specify)                   | i idilii, dili   | out, factory, office                          |                              |                          | City or Town,                         |                            | 7.501 01 71510                |                                     |
|                     | To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral   | edical C   | 29a. Certifier (Check only one) Certifyii   | ng Physician: To the<br>Examiner: On the b | pasis of   | examination                 | ige, death<br>and/or inv   | occurred at the time<br>restigation, in my or | ne, date and<br>pinion, deat | d place, a<br>th occurre | nd due to the ca                      | use(s) and<br>te and place | manner as si<br>e, and due to | tated. o the cause(s)               |
|                     | To the within 2 To the complet   | Mec  | 29b. Signature and title of certifie  | and mar                                    | nier Stat  | .64.                        |  | 29c. License                                  | number                       |                          | 29                                    | d. Date sign               | ned (Month,                   | Day, Year)                          |
|                     | 2  |  | · Whi   | hum  |            |                             |  | Do  | 0337                         | 280                      |                                       | Mai                        | 12,2                          | 00 8                                |
|                     |  |  | 30. Name and address of person  |  |            |                             |  |   |                              |                          |                                       |                            |                               |                                     |
|                     | 71 XS  |  | Sunil K. 31. Date filed (Month, Day, Year)  | Gupta, N                                   |            | , 625<br>r's Signature      |  | t Avenue,                                     | Cumb                         | berla                    | and, MD                               | 2150                       | 2                             |                                     |
|                     | Sta<br>Registr   | MAV D 5 2008 Read A Part A Par |   |  |            |                             |  |   |                              |                          |                                       |                            |                               |                                     |

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Month Vear VERNA FLORENCE BENSON 30008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ALLEGANY LIONS CENTER CUMBERLAND THE If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) JAN 9,1923 9. Birthplace (State or Foreign **Funeral** Hours Days 1 ☐ M 2 💢 F PENNSYLVANIA 578-20-7789 85 JAN. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show ner must be notified at 1 ☐ Yes 2 X No Director MINERAL RIDGELEY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ROUTE 1, BOX 184-A 26753 U.S.A. by Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: WHITE 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) WAITRESS RESTAURANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ALVIN C. DREAS FLORENCE K. GABEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. BOX 613, RIDGELEY, WV 26753 A. THOMAS BENSON / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CUMBERLAND CREMATORY 05/16/2008 CUMBERLAND, MD 21. Signature of Funeral Service License Name and Address of Facility UPCHURCH FUNERAL HOME, P.A 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Heart Congestive menth resulting in death) /Medicai Due to (or as consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant et time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 mon 1 Yes 2 No 3 Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an Ñ autopsy performed? res 2 No page funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide LXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division or Vital Records, P.O. Box 68760. within 24 hours after death To the Funeral Director:

3altimore, Maryland 21

nds Registrar (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 925 Bishop Walsh Rd, Cumberland, MD21503

wowselfeller

MAY 1 5 2008

Pagistrar's Signature

8

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** EUGENE COMBS 05 2008 2100 /Medical 16 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY if Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 22, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1√ M 2□ F Months Days Hours Director 162-22-7751 80 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d, inside City Limits must be notified at WV Mineral Fort Ashby 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural", or Items 23a or 26719 USA Country Villa Apt. 121 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 12☐ Yes 2 ☐ No if Yes, Give Year or Dates: 1946-48 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) permit, Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important; if frem 27 is marked other that any Injury or other traumout. Supervisor WV State Rd. Dept. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wade Combs Ethel Maphis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P O Roy 903 Romney WV 26757 19a. Informant's Name/Relationship (Type. Print) daughter Judy Lewis 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State **Ebenezer Cemetery** 5/20/2008 WV Romney 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Home, PA for Shaffer FH, Romney, W 21. Signature of Funeral Service Licenset 108 Virginia Avenue: Cumberland, MD 21502 \_0 23a Fart Enter the disease or conforcations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) CONGESTIVE HEART FAILURE **Physician** DAYS /Medical Due to (or as a consequence of) Examiner NEUMON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an autopsy performed? 1∐ Yes 2 No STEOMYELITIS OF THE LEFT 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FOOT 25. Was case referred to medical examiner? To the HospItal or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 10062177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VICTOR CRENTSIL, MD 5 SETON DRI CUMBERLAND, MD 21502 31. Date filed (Month, Day, Year) . Registrar's Signature State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** V. Carla Coles May 17 2008 11:01A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton Prince Georges 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1□M 2□ Director 577-82-3481 43 Dec.13,1964 Wash., DC Usual Residence of Decedent within 72 hours after death with the Maryland a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director Md. PG Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or Items 23a 20746 United States 3705 Silver Park Drive #102 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify 2 3 ☐ Widowed 4 ☐ Divorced Black r than "natura the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) "u be filed with. and Mental Hygiene. or traumatic ever Elementary/Secondary (0-12) College (1-4or 5+) Pharmacy Technician CVS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Robert Coles Barbara Thomas ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 370.5 Silver Park Drive #102
Suitland, Md. 20746

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Le permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is
any Injury or other trai
once. Barbara Coles/mother 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cem. 5/22/08 Clinton, Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service Licenses 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Part1 Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE PRASSIVE PULMORARY EMBOLISM **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit the death certificate be executed Due to (or as a consequence of) Physician/Medical the as attending I 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Nonknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an page 2 certificate Yes 25. Was case referred to medical examiner? director Be 26 Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient this 27. Manner of Death 1 ☐ Natural 2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier

Box 68760. Records, P.O. Vital o Division

the Hospital or Attending within 24 hours aft

To the Funeral DI

completely filled in

State

Medical

(Check only one)

29b. Signature and title of certifier

CONTHERN

31. Date filed (Month, Day, Year) MAY 2 7 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AN LEMATA AN MD

HOS DITAL

29c. License number

A50689

ENTER 7503

29d. Date signed (Month, Day, Year,

SHRLATTS RD CLINTON MD

and manner stated.

32. Registrar's Signature

Maha

MARY

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0052999

29d. Date signed (Month, Day, Year)

death certificate be executed O. Box 68760.

Maryland 21215-0036

Baltimore,

۵ Division or Vital Records, Hospital or Attending ospital c.
4 hours after dec.
7. neral Director: After within 24 hours after
To the Funeral Dire
completely filled in b To th. within 2.

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier (Check only one)

29b. Signature and the of o

10403 Hospital Drive GG CLINTON RAHIMIAN MD, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8-12AM DRINKARD ALICIA MAY 2008 17 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Howard County General Hospital Columbia Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1□M 2**X**1F November 30, 1959 Ohio Director 48 300-64-7929 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County th and Mental Hygiene. 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐Yes ¾☐No Ellicott City Director Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 21043 U.S.A. Ida Drive 3560 Mt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 ☐ Widowed ▼ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Waitress Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ruby P. Porter Donald Wilkes 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If Item 27 Is any Injury or other trauonce. 113 Wilmington S.E., Washington, DC 20032 lace of Disposition (Name of Date 20c. Location - City or Town, State Mark Pooler, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-22-08 Moraine, Ohio WestMemoryGarden 21. Signature of Funeral Service Licensee Marzullo Funeral Chapel, P.A 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNEUMONIA 20 to ACINETO BACTER Physician doup /Medical Due to (or as a consequence of): Examiner 20 N ACINETO BACTER SEPSIS if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ot): Examine moneto Svage Durease The law requires that the death certificate be executed renal burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, AIDS Immuno deficiency Monets Physician/Medical A cquired attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed2 1 ☐ Yes 2 ☐ No 1□ Yes 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Impatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🛩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

DOOS 3150 NAY 17 200 8 Spipte MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sentiago Rd Suite 110 SHAKUNMALA GUPTA 9650

14021045

State Registrar

10

31. Date filed (Month, Day, Year)

2. Registrar's Signature

|  |                   | Please Type or Pri  |  |  | Ensure All Copid<br>lealth and Mental H  |                           |  |  |
|--|-------------------|---|--|--|--|---------------------------|--|--|
|  | •                 | For<br>State<br>Registrar   |  | rtificate of L   |  | Reg. No                   | 0000   | 17053  |
| Physici<br>/Medio  |                   | 1. Decedent's Name (First, Middle, Last) William Potter Dukes   |  |  | 2. Date of Month   | Death Da                  | 2008   | 3. Time of Death                                   |
| Examir<br>Funeral<br>Director  |                   | 4a. Facility Name (If not institution, give street and number  VA Moury land Health Co.  5. Social Security Number  212-34-2122  A M 2 F 7  | re Sistem<br>ge (In yrs. Tast birthday,              | Perry  | Fort Hours Min. 10/979   | Birth 71936               | 9. Bir                                       | thplace (State or Foreign<br>buntry)               |
| ъ  |                   | Usual Residence of Decedent  10a, State 10b, County   | 10c. City, Town or Lo                                | ocation  |  |                           |  | 10d. Inside City Limits                            |
| f show   | ō                 | MD Caroline   | Denton   | ocation  |  |                           |  | 1 X Yes 2 □ No                                     |
| the N  | Director          | 10e. Street and Number  |  | 10f. Zip Code  |  | 10g. C                    | itizen of What Co                            | puntry?  |
| 3a or  | a Di              | 400 South Second Street   |  | 21629  |  | Uni                       | ted Sta                                      | tes  |
| 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Evertinet must be notified at   | by Funeral        | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ▼ Divorced  12. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 12. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 14. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 15. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 16. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 17. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 18. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 19. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 10. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 10. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 10. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 10. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 10. Was Deceden Armed Forces 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 ▼ 1 □ Never Married 1 □ Never Mar | ?<br>  No  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 XNo         | ispanic Origin? (Specify Yes or<br>an, Mexican, Puerto Rican, etc.<br>Specify: | No-                       | 14. Race - Ame<br>Black, Whit<br>Specify Cau | e, etc.  |
| in 72 hour<br>n "natural<br>Jedical Ex   | Completed t       | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Dece<br>(Give<br>life.                          | edent's Usual Occup<br>e kind of work done o<br>DO NOT use retired | 7.   | Kind of Business          | •  |  |
| d with<br>giene<br>er tha  | Com               | Elementary/Secondary (0-12) College (1-4or  | tea tea  | cher/publ  |  |                           |  | /printed me  |
| < 0 m c  | To Be (           | 17. Father's Name (First, Middle, Last) Levi Reyner Dukes   |  | Maiden Surname)<br>Villey  |  |                           |  |  |
| es 1 and 2 should b<br>of Health and Ment<br>f Item 27 is marked<br>r other traumatic e  |                   | 19a. Informant's Name/Relationship (Typa Print)<br>Anna Dukes / daughter  | 19b, Mail<br>23 E                                    | ing Address <i>(Street</i><br>Last Dover                           | and Number or Rural Route No. St., Easton,                                     | "MD" 21                   | or Town, State,                              | Zip Code)  |
| permit. Pages 1 a Department of Hee Important: If Item any Injury or othe  |                   | 20a. Method of Disposition  1 ☐ Burial 2X☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)   |  | osition (Name of<br>ematory or other place<br>Crematory            |  |                           | Location - City or<br>ver, DE                | Town, State  |
| permit. Departm Importar any Inju  |                   | 21. Signature of Funeral Service License  | , a  | 22. Name and Addre<br>Moore Funera                                 | ss of Facility<br>all Home, P.A., 125  | S. Secon                  | ndSt., Der                                   | nton, MD 21629                                     |
| Physician<br>/Medical<br>Examiner  |                   | 1   | ed the death. Do not er<br>line.<br>s a consequence: | Fibros   | ng, such as cardiac or respirato   | ry arrest,                |  | Approximate<br>Interval Between<br>Onset and Death |
| ficate be executed<br>physician and<br>s the burial-transit  | dical Examiner    | cause. Enter Underlying Cause (Disease or injury that initiated events  | s a consequence of):                                 |  |  |                           |  |  |
| eath certi<br>attending<br>for use a   | Physician/Medical |   | 2 ☐ Fetal death 3<br>at time of death 5              | ☐ Ectopic pregnanc   | у  | _                         | 23d. Date of de<br>Month                     | elivery<br>Day Year                                |
| w requires that the d<br>s been signed by the<br>should be detached  | ğ                 | Part II. Other significant conditions contributing to death   | but not resulting in the                             | underlying cause giv   | Silini tartii  |                           | o use contribute to                          | o the cause of death?<br>Probably 4 Unknov         |
| Physician: The law rec<br>this certificate has bee<br>al director, page 2 shou   | Completed         |   | <u></u>  |  |  | Was an autopsy performed? | prior to death?                              |  |
| clan:<br>sertific<br>setor,  | Be (              | 25. Was case referred to medical examiner?  |  | Total  | 26. Place of Death (Check o  | nly one)                  |  |  |
| Physl<br>this c  | ျ                 | 1 ☐ Yes 2 No Hospital: 1 Inpa  27. Manner of Death 28a. Date of Ir  | tient 2 ER/Outpatie                                  |  | 4 Li Nursing Home 5 Li   |                           | 6 ☐ Other (Sp<br>jury occurred               | ecify)   |
| or Attending Phy<br>after death.<br>Director: After thi<br>in by the funeral   | Certification:    | 1 Natural 5 Pending (Month, L<br>2 Accident investigation<br>3 Suicide 6 Could not be 28e. Place of I   | <i>jay, Year)</i> Injury                             | M 1□   | k̃?<br> Yes 2 □ No<br>  28f. Locati  |                           | and Number or F                              | -<br>Bural Route Number,                           |
| To the Hospital or within 24 hours afte To the Funeral Dire completely filled in the state of th | Medical Cert      | 29a. Certifier (Check only one)  Certifying Physician: To the besigned and manner and manner  | of examination and/or                                | ath occurred at the ti<br>investigation, in my o                   | ime, date and place, and due to  | the cause                 | (s) and manner                               | as stated.<br>se to the cause(s)                   |
| To the within ?  | Mec               | 29b. Signature and title of certifier   |  | 29c. Licens  | 00 32 548  |                           | Date signed (Mor                             | nth, Day, Year)                                    |

State Registrar 31. Date filed (Month, Day, Year) 1 9 2008

DHMH 17 Rev 1/2001

ress of person who completed cause of death (Item 23a) (Type, Print)

Divin, M.D., VA Maryland Health Care System, Perry Pant MD 2902

Thin, Day, Year)

R 1 9 2008

|  |   |   | 1_   |
|--|---|---|--|
|  | Physicia<br>/Medic<br>Examin  | al  | 1. De  |
|  | Funeral<br>Director   |   | 5. Sc<br>2.<br>Usua  |
| Baltimore, Maryland 21215-0036             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | To Be Completed by Funeral Director               | 10a.  10a.  11a.  11a.  11a.  11a.  11a.  11a.  11a.  11a.  12a.  12a.  21a. |
| 1  |   |   | 23a  |
| )  | Physician<br>/Medical<br>Examiner   | 16  | discres  |
| 58760,                                     | ficate be executed<br>physician and<br>s the burial-transit   | edical Examiner                                   | tha<br>res   |
| O. Box (                                   | the death certing the attending ched for use a  | ysician/Me  | IF 6   |
| Division or Vital Records, P.O. Box 68760, | or Attending Physician: The law requires that the death certificate be executate death.  Einector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-trans-                                       | rtification: To Be Completed by Physician/Medical | Par  |
| Vital                                      | sician:<br>certifical<br>irector, p   | Be C  | 25.  |
| Division or                                | i or Attending Physia er death. Director: After this in by the funeral di   | ertification: To                                  | 27.  |

sign. page 2 certificate this After this funeral of within 24 hours a er death. To the Funeral Director: filled in by the completely

Certificate of Death Reg. No. 2. Date of Death ecedent's Name (First, Middle, Last) Dav 10:00P 2008 MAY 8 THELMA JEAN DEFRIECE 4c. County of Death 4b. City, Town, or Location of Death acility Name (If not institution, give street and number) JEFFERSON Inder 1 Year | If Under 24 Hrs. FREDERICK 3706 POINT OF ROCKS ROAD 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 M 2 F Yrs. 20-56-3592 54 7 1953 NOV al Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☑ No MD FREDERICK **JEFFERSON** 10g. Citizen of What Country? 10f. Zip Code Street and Number 21755 ROCKS ROAD

12. Was Decedent Eyer in L
Armed Forces? USA 3706 POINT OF 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give ☐ Never Married 2/☐ Married 1 ☐ Yes 2 ☑ No Specify. WHITE Specify: It Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)

SELF EMPLOYED lementary/Secondary (0-12) College (1-4or 5+) CLEANING 12 HOUSEKEEPER 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) HALLDANE COUNSEL BURGESS JULIA JOSEPHINE EDWARDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Informant's Name/Relationship (Type. Print) 3706 PT. OF ROCKS RD., JEFFERSON, MD 21755 ACK DeFRIECE / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 D Burial 2 □ Cremation 3 □Removal from State 5/13/08 MT. OLIVET CEMET. FREDERICK, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HILTON FUNERAL HOME
P.O. BOX 86, BARNESVILLE, Signature of Juneral Service/Liq ensee 20838 n. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final LUNG CANCER ease or condition ulting in death) Due to (or as a consequence of): quentially list conditions, ny, leading to immediate use. Enter Underlying Due to (or as a consequence of): use (Disease or injury t initiated events ulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 1□ Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural
2 □ Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 9, 2008 53177 30. Name an Address of person who completed cause of death (Item 23a) (Type, Print) 9707 MEDICAL CENTER DR., ROCKVILLE, MD JOHN WALLMARK, MD 20850 32. Registrans Signature 31. Date filed (Month, Day, Year) State 2 2008

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Month Day 2008<sup>ear</sup> 8. 1:10P. May **Physician** Susanne Imlav Dhyse /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number)
Renaissance Gardens at Riderwood Village Examiner Silver Spring Prince George's If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept. 25 9. Birthplace (State or Foreign Country) New Jersey 7. Age (In yrs. last birthday) 5. Social Security Number 217-34-1363 6. Sex **Funeral** Months Days Hours 88 1 □ M 2 💢 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show rai", or Items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Maryland | Prince George's Silver Spring Director 10g. Citizen of What Country? 10f. Zip Code 3160 Gracefield Road, #1223 20904 United States death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black. White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Married Specify: White 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 ò 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Ames William Fullerton Imlay P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 542 Broadwater Road Arnold, Maryland 21012 Paul W. Dhyse -son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Paurial 2 □ Cremation 3 □ Removal from State 0 Parklawn Memorial Park 5/12/2008 Rockville, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland20705 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebral Vascular Accident **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cerebral Vascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Atrial Fibrillation burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physiciar use as the attending p for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 X No 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Dementia been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2X No 24a. Was an certificate has be inector, page 2 s autopsy performed? Yes 2 No 1 director, 26. Place of Death (Check onl one 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 № No 1 Inpatient Certification: To this After thi funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 5 □Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident within 24 hours after death.

To the Funeral Director: A completely filled in by the f 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

DHMH 17 Rev 1/2001

State Registrar (Check only one)

31. Date filed (Month

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated

MD who completed cause of death (Item 23a) (Type, Print)

strar's Signature

Medion

Travis Ray Everett
08-03575

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
UNK UNK

State of Maryland / Department of Health and Mental Hygiene

|                 | 1- For State<br>Registrar  | Cer  | tificate of L  | Death                             |                            | Reg. f   | 10 20C                        | 18 1705   |  |  |
|-----------------|--|--|--|-----------------------------------|----------------------------|--|-------------------------------|---|--|--|
| an/<br>ner      | Decedent's Name (First, Middle,Last)   |  |  | <del></del>                       |                            | Date of Death     Month Da   | ıv Year                       | 3. Time of Death<br>0734 hrs                      |  |  |
| Hei             | 4a. Facility Name (if not institution, give stre   | eet and number)  | Everett 4b   | . City, Town, or L                | ocation of Death           | May 10, 2008   | 4c. County of Deat            |   |  |  |
|                 | W/B Route 51 at Kerns Ceme   | tary Road  |  | Oldtown                           |                            |  | Allegany                      |   |  |  |
|                 |  |  | ast birthday)<br>Yrs.  | If Under 1 Year<br>Months Days    | If Under 24Hrs. Hours Min. | ,  | Forei                         |   |  |  |
|                 | 10a. State 10b. County   |  |  |                                   |                            |  |                               | 10d. Inside City Limits                           |  |  |
| ē               |  | hire   |  |                                   |                            |  |                               | 1 Yes 2 X No                                      |  |  |
|                 | HC 86 Box 34   |  |  | 10f. Zip Code                     | 26722                      | 10g.   |                               |   |  |  |
| inera           | 11. Marital Status  1 X Never Married 2 Married  | Armed Forces?  |  |                                   |                            |  | 14. Race - Ame<br>White, etc. | rican Indian, Black,                              |  |  |
|                 | l or l   | es, Give Yeer  |  |                                   |                            |  |                               |   |  |  |
|                 |  |  |  |                                   |                            |  | b. Kind of Business           | /Industry   |  |  |
| mple            | 12   | Soliege (Fire Siry)  | excav  | ation                             |                            |  | excavatir                     | ng business                                       |  |  |
| ပ               | 17. Father's Name (First, Middle, Last)  Kevin R. Everett  |  |  |                                   |                            |  |                               |   |  |  |
| P P             | 19a. Informant's Name/Relationship (Type,  | Print )  |  |                                   | and Number or F            | Rural Route Number   | , City or Town, Stat          |   |  |  |
|                 |  |  |  |                                   |                            |  | <u> </u>                      | WV 26722  |  |  |
|                 |  | 1  |  |                                   | letery,                    |  |                               |   |  |  |
| п               | 4 Donation 5 Other Specify: 21. Signature of Funeral Service/Licensee  |  |  | me and Address                    | of Facility                |  | <u>.</u>                      | •••,  |  |  |
|                 | 1/1/1/1/1/   | / /  |  | Scarpe                            | Ili Funeral H              | lome, PAfor  | Shaffer FH                    | , Romney, WV                                      |  |  |
|                 | 2 Tert I. English the later as your complication of the later and the la | or that caused the death.<br>ne.   | Do not enter the   | mode ying                         | YATI AS CONNECTA           | respiratory and st.  | shook or heer 02              | Approximate Interval<br>Between Onset and         |  |  |
|                 |  |  | f).  |                                   |                            |  |                               | Death   |  |  |
|                 | Sequentially list conditions.  |  |  |                                   |                            |  |                               |   |  |  |
| iner            | if any, leading to immediate Due to (or as a consequence of):  |  |  |                                   |                            |  |                               |   |  |  |
| xam             | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |  |  |                                   |                            |  |                               |   |  |  |
|                 | d.   | AENDED.  |  |                                   | <del></del>                | <u>.</u>   |                               | <del></del>                                       |  |  |
| Nedi            |  |  | nancv  |                                   |                            | - 1  | 23d. Date of delive           | IIV   |  |  |
| ian/l           |  | Live birth   | 2 Feta   | I death 3                         | Ectopic pregna             |  | Month                         | Day Year  |  |  |
| ysic            | 1 Yes 2 No 9 Unknown g   |  | 5 Othe   | r (Specify)                       |                            |  |                               |   |  |  |
|                 | Part II. Other significant conditions con  | tributing to death but not re  | esulting in the un   | derlying cause gi                 | ven in Part I.             |  |                               |   |  |  |
|                 |  |  |  |                                   |                            |  |                               |   |  |  |
| Bet             |  |  |  |                                   |                            | autopsy  | prior to                      | autopsy findings available completion of cause of |  |  |
| E O             |  | and the same of th |  |                                   |                            | 1 Yes 2  | No 1                          |   |  |  |
|                 | 25. Was case referred to medical examiner?   | tal:   |  |                                   | Othor: -                   |  |                               | _   |  |  |
| 욘               | 1 Yes 2 No   | 28a. Date of Injury  |  | 0                                 | T THOISIN                  |  | 1                             | er: Scene   |  |  |
| ţ               | 1 Natural 5 Pending  | (Month, Day Year)<br>May 10, 2008  | 0657 hrs   | · I :                             |                            | Driver auto au   |                               |   |  |  |
| ္ဗႏ             | 2 Accident Investigation 3 Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or R   |  |  |                                   |                            |  |                               |   |  |  |
| ا≘              | The standard of the standard o |  |  |                                   |                            |  |                               |   |  |  |
| Certification:  | 4   Homicide   | inajo: riou  |  |                                   |                            |  |                               |   |  |  |
|                 | 29a. Certifier (Check only one) 2 Medical Examiner: On   | To the best of my knowledg   |  |                                   |                            |  |                               |   |  |  |
| Medical Certifi | 29a. Certifier (Check only one) 2 Medical Examiner: On   | To the best of my knowledg   |  |                                   | death occurred a           | it the time, date and  |                               | the cause(s)                                      |  |  |
|                 | 29a. Certifier (Check only one) 2 Medical Examiner: On and   | To the best of my knowledg   |  | n, in my opinion,                 | death occurred a           | t the time, date and   | place, and due to             | the cause(s)                                      |  |  |
|                 | 29b. Signature and title of certifier  30. Name and address of person who comp   | To the best of my knowledge the basis of examination are manner stated.  | nd/or investigatio   | 29c. License<br>O.C.M             | death occurred a           | at the time, date and  | place, and due to             | the cause(s)                                      |  |  |
|                 | To Be Completed by Physician/Medical Examiner To Be  | Usual Residence of Decedent  10a. State  10b. County  WV  Hamps  10e. Street and Number  HC 86 Box 34  11. Marital Status  1   | Usual Residence of Decedent   10a. State   10b. County   10c. City,   10c. Street and Number   10c. Street and Number   11c. Married   11c. | 234-21-1107   1 X M 2 F 27   Vrs. | 234-21-1107                | 234-21-1107   1   M 2   F 27   Vrs.   Months   Days   Hours   Min. | 234-21-1107                   | 234-21-1107                                       |  |  |

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|----------|------------|-----------------|-------------|-----------|------------|------|
| State of | Maryland / | Department of   | of Health a | and Menta | al Hygiene | 00   |

| •       |           |
|---------|-----------|
| 5/13/08 | For State |

301-631-6877

Physicia /Medic Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23 a or 28a-f show any injury or other traumatic event, I'm Madical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

P.O. Box 68760, Division of Vital Records,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

0+31

| David A. Penglehart   Section from the common of the com   |   | 1 - State Registrar Certificate of Death Reg. No.          |                                   |            |                      |              |            |                 |                  |                   | JUO                 | 1/1            | U D /      |  |
|--|---|--|-----------------------------------|------------|----------------------|--------------|------------|-----------------|------------------|-------------------|---------------------|----------------|------------|--|
| David A. Englehart  4.8 First James (for Shadder, page award and number)  238 North Market Street Apt. 3  5. Second South Parket Street Apt. 3  5. Second South Parket Street Apt. 3  6. Second South Parket Street Street Street Street Street Street Street Street |   | 1. Decedent's Name (First, Middle, Last)                   |                                   |            |                      |              | eath       | )av             | Vear             | 3. Time of        | Death               |                |            |  |
| 2.38 North Market Street Apt. 3   Frederick   Frederic | n<br>al   | David A. Englehart   |                                   |            |                      | May 9        | 9, 2       | 800             | 1001             | 4:30 <sub>I</sub> | М (                 |                |            |  |
| The property of the property   | er  | 4a. Facility Name (If not institution, give street         | and number)                       | 4          | 4b. City, Town, o    | Location     | of Death   |                 | 4                | c. County         | y of Death          |                |            |  |
| The processing of the process of t   |   | 238 North Market Str                                       | eet Apt. 3                        |            | Frederio             | k            |            |                 |                  | Fred              | erick               |                |            |  |
| United States of Percent   |   | 5. Social Security Number 6. Sex                           |                                   |            |                      |              |            | 8. Date of E    | irth<br>Day, Yea | r)                | 9. Birthpl          | ace (State o   | r Foreign  |  |
| The State      |   |  | 48                                | Yrs.       |                      |              |            | 07/25           | /195             | 9                 | West                | Virgi          | nia        |  |
| MD   Frederick   Frederick   13/12   100   13/14   100     |   |  | 10c City Tow                      | n or Loca  | tion                 |              |            |                 |                  |                   | 1/                  | nd Inside Cif  | tv I imits |  |
| Samuel I. F. Englehart (mother)  19a. Informarts Name/Relationship (Type Print)  19a. Informarts Name/Relationship (Type Print)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number or Rural Route Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street and Number; City or Town, Stato, Zip Code)  19b. Mailing Address (Street)  19b. | 'n  |  |                                   |            | uon                  |              |            |                 |                  |                   | '                   |                |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | ect   |  | Freder                            | ick        | 101 75- 0-1-         |              |            |                 | 100              | Distance of       | What Court          |                |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | 늅   |  |                                   |            |                      |              |            |                 |                  |                   |                     |                | morio      |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | eral  | T to II  |                                   | 140.141    |                      |              | :-i=0 /C=  | anif. Van ov b  |                  | _                 |                     |                | mer ic     |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | Š   | A A  | rmed Forces?                      | IS. WE     | es, specify Cuba     | an, Mexicai  | n, Puerto  | Rican, etc.)    | 10-              |                   |                     |                |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | Ş   | _ If   | Yes, Give                         | 1 [        | ∐Yes 2 <b>XXX</b> No | Specify:     |            |                 |                  | Specia            | <sup>fy:</sup> Whit | :e             |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | ed  |  | 11                                | . Decede   | nt's Usual Occup     | ation        |            |                 | 16b.             |                   |                     |                |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | plet  | (Specify only highest grade com                            | pleted)                           | (Give kii  | nd of work done      | durina mos   | t of worki | ing             | 1                |                   |                     | •              |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | EO  | Elementary/Secondary (0-12)                                |                                   | ttor       | ney                  |              |            |                 | L                | aw                |                     |                |            |  |
| Samuel I. F. Inglehart  19a. Informarts hame/Relationship (Type-Print)  19a. Informarts hame/Relationship (Type-Print)  19b. Mailing Address (Street and Number or Rural Route N | e<br>O  | 17. Father's Name (First, Middle, Last)                    |                                   |            |                      | 18. Moth     | er's Name  | (First, Midd    | le, Maid         | en Surnai         | me)                 |                |            |  |
| 199. Informatic Name/Relationship (Type, Print)   199. Mailing Address (Sineet and Number or Rush Roule Number, City or Town, State, Zip Code)   13.00 Glade Driftyee Apt 11-2E Silver Spring, MD 20906   200. Mailing Address (Sineet and Number or Rush Roule Number, City or Town, State, Zip Code)   15.00 Glade Driftyee Apt 11-2E Silver Spring, MD 20906   200. Market of Deposition (Paper)   15.00 Glade Driftyee Apt 11-2E Silver Spring, MD 20906   200. Location - City or Town, State   200. Date   200.    | О   | Samuel E. Englehart  |                                   |            |                      | Jane         | t The      | eilgar          | 1                |                   |                     |                |            |  |
| 22. Memoral Disposition 1   Bural 2   Commanda 1   Bural 2   Command | _   | 19a. Informant's Name/Relationship (Type. P.               | rint) 19t                         | o. Mailing | Address (Street      | and Numb     | er or Rura | al Route Nun    | ber, Cit         | y or Town         | , State, Zip        | Code)          |            |  |
| 22. Merco of Disposition (Name of Legislation) and Place of Disposition (Name of Legislation) and Place of Disposition (Name of Legislation) and Place of Disposition (Name of Legislation) and Place of Disposition (Name of Legislation) and Place of Disposition (Name of Legislation) and Place of Disposition) and Place of Disposition (Name of Legislation) and Place of Disposition) and Place of Disposition (Name of Legislation) and Place of Disposition) and Place of Disposition (Name of Legislation) and Place of Disposition (Name of Statistics) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name of Disposition) and Place of Disposition (Name o |   | Isnet T Englehart  | (mother) 1                        | 5100       | Glade Di             | rive .       | Ant '      | 11-2E           | Silv             | er S              | oring.              | MD 2           | 0906       |  |
| Burnal 2 glownation 3   Chemical Foreinosal from Slate   Stauffer Crematory   05/12/2008   Frederick, Maryland   |   | 20a. Method of Disposition                                 | 20b. Place o                      | f Disposit | ion (Name of         | - :          |            |                 |                  |                   |                     |                |            |  |
| 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Stauffer Funeral Home  1621 Oppssumtown Pike Frederick, MD 21702  236 Fert I test (b) bissues, or congulations that cloude by deep to not enter the mode of dying, such as cardiac or respiratory arrest, interval Batween Interval Batween  |   |  | al from State I                   |            |                      |              | 05/12      | 2/2008          | Fre              | deri              | ck, Ma              | arylan         | d          |  |
| 1621 Opposium town Pike Frederick, MD 21702   234-304   245-304    |   |  |                                   |            |                      |              | ty C + a - | .ffor           | Funo             | wo1 1             | Uomo                |                |            |  |
| Approximate shock or heartfailure. Litton you cause on each line.    Carrier   | Yannialing 4   | Dallarta                          | 16         | 21 Opace             | numt o       | otai       | ika Er          | odor             | ick               | MD 2                | 1702           |            |  |
| Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a |   | 23a. Part 1. Enter the disease, or complication            | ns that caused be death. Do       | not enter  | the mode of dyir     | ng, such as  | cardiac    | or respiratory  | arrest,          | LCR               | 1110 2              | Approximate    | 9          |  |
| Sequentially list conditions   Due to (or as a consequence of):   Due to (or as a co   |   | Immediate Cause (Final                                     | use on each line.                 | ~^         | MOD                  | at           | 14         |                 |                  |                   | 1                   | Onset and D    | Death      |  |
| Sequentially list conditions, imply leading to immediate cause. Either Underlying cause growth and the course of the cause of the cause of the course of the cause  |  | Due to (or as a consequence       | of):       | 201                  | 1            |            |                 |                  |                   |                     | <u>&gt; 30</u> | C V.S      |  |
| Due to (or as a consequence of):    Due to (or as a consequence of):   Accumple of pregnancy   1   Live birth 2   Fetal death 3   Composite and   23d. Date of delivery   Month Day Year   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Fetal death 3   Composite and   1   Live birth 2   Live birth 2   Fetal death 3   Composite and   2   Live birth 2   L |   |  |                                   | 1          | ١(                   |              |            |                 |                  |                   |                     |                |            |  |
| Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of to the counce of the to the cause of dealth on the counce of the counce of the counce of dealth on the counce of the counce of the counce of dealth on the counce of the counce of dealth on the counce of | ĕ   | Sequentially list conditions, if any, leading to immediate | Due to (or as a consequence       | of):       | Accending Acres      |              |            |                 |                  | PAVRA             |                     |                |            |  |
| FFEMALE:   | Ē   | Cause (Disease or injury                                   | neurysm i                         |            | 1300                 |              | ) 11.15    | composite Acres |                  |                   |                     |                |            |  |
| 236. By so, uctome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown 9   Unkno | Š   | resulting in death) Last                                   | Due to (or as a consequence       | of):       |                      |              |            | (               | 300              | VT                |                     |                |            |  |
| 236. By so, uctome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown 9   Unkno | ca  |  |                                   |            |                      |              |            |                 |                  |                   |                     |                |            |  |
| 236. By so, uctome of pregnancy 1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown 9   Unkno | ed  |  |                                   |            |                      |              |            |                 |                  |                   |                     |                |            |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | -   | 23b. Was decedent pregnant 23c. If                         |                                   | . a□       | Estania aragnana     |              |            |                 |                  | 23d. Da           | ate of delive       |                |            |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | Sicial  | 1 DVes 2 DNo   | Pregnant at time of death         |            |                      | У            |            |                 |                  | M                 | onth                | Day Y          | /ear       |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | h   | 9 ☐ Unknown  | - Oliknowii                       |            |                      |              |            |                 |                  |                   |                     |                |            |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | S.  | Part II. Other significant conditions contribut            | ting to death but not resulting i | n the und  | erlying cause giv    | en in Part I | ١,         | 23e. Did        | tobacc           | o use con         | tribute to th       | e cause of d   | leath?     |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | ed  | Congestive   | Heavit t                          | cell       | uve                  |              |            | 1 [             | Yes              | 2 No              | 3 ☐ Prob            | ably 4□ U      | Jnknown    |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | bet   | Depression   | )                                 |            |                      |              |            |                 |                  | 24b.              | Were autor          | osy findings   | available  |  |
| 25. Was case referred to medical examiner?  1   Yes   2   No   | E   |  |                                   |            |                      |              |            | per             | formed           | R I               | death?              |                | ause oi    |  |
| 1   Yes   2   No   No.   | e<br>C  |  |                                   | -          |                      | 26. Place    | e of Death |                 |                  | 10                | 1 163               | 2 110          |            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  |   |  | al: 1   Inpatient 2   ER/O        | utpatient  | 3 □ DOA Oth          | er: 4 🗆 N    | ursing Ho  | me 5 Re         | sidence          | 6 □ Ot            | her (Specifi        | v)             |            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  | 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred   |  |                                   |            |                      |              |            |                 |                  |                   |                     |                |            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  | atio  |  | (Monni, Day, rear)                | ,,         |                      |              | No         |                 |                  |                   |                     |                |            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  | III (i  |  | te. Place of Injury - At home, fa | arm, stree | t, factory, office   |              | - 11       | 28f. Location   | (Street          | and Num           | ber or Rura         | l Route Num    | ber,       |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  | Cer   | . Lavisinos  | bulleting, etc. (opcony)          |            |                      |              |            | Ony or 1        | o w 11, O ti     | 110)              |                     |                |            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |                                   |            |                      |              |            |                 |                  | 170               |                     |                |            |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE  31. Date filed (Month, Day, Year)  32. Registratés Signature  SUITE 202  | edic  |  |                                   |            | auganon, m my (      | риноп, де    | atti occur | ieu ai trie tim | e, uale i        | ли ріасе          | , and due to        | uie cause(S    | 7)         |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  NIRMAL K SHAH MD FACC 180 THOMAS JOHNSON DRIVE 31. Date filed (Month, Day, Year) 32. Registrate Signature  | Σ   | 29b. Signature and title of certifier                      | A. 0                              |            | 29c. Licens          | e number     | 7 1        | 27              | 29d. I           | Date sign         | ed (Month, i        | Day, Year)     |            |  |
| 31. Date filed (Month. Day, Year)  32. Registrade Signature  33. Registrade Signature  |   | > Now  | Chah                              |            | PC                   | US           | -+         | UT              | C                | 5/1               | 209                 | 3              |            |  |
| 180 THOMAS JOHNSON DRIVE 31. Date filed (Month. Day, Year) 32. Registrate Signature 33. Date filed (Month. Day, Year)  |   | 30. Name and address of person who comple                  | ted cause of death (item 23a)     | (Type, Pr  | int)                 |              |            |                 | NIRM             | AL K              | SHAH M              | D FACC         |            |  |
| 31. Date filed (Month, Day, Year)  32. Registrace Signature  SUITE 202 FREDERICK MD. 21702   |   |  |                                   |            |                      |              |            |                 | 180 T            | HOMA              |                     |                |            |  |
|  | е   | 31. Date filed (Month, Day, Year)                          | 32. Registrar's Signature         | L          | Angel 1              | 6            |            |                 | SUIT             | : 202<br>ERICI    | K MD. 2             | 21702          |            |  |

State Registrar

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

MICHAEL

29b. Signature and title of certifier



30. Name and address of person who completed caus, of death (Item 23a) (Type, Print)

10

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 10, **Physician** Fischer 114 PM M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Bethesda Suburban Hospital Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May | 7923 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** New York 1 ☐ M 2 💢 F 100-14-4755 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1▼Yes 2 No MD Director Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 18468 Heritage Hills Drive 20832 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White ₽ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own\_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Fannie Fraundinst Joseph Silverman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela Aspland - Daughter 18468 Heritage Hills Drive Olney MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) King David Memorial Gardens 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 5/12/08 Falls Church, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels Inc 1170 Rockville Pike Rockville MB 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Aspiration Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Gastrointestinal Bleeding Sequentially list conditions, if any, leading to in mediat cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Chronic Lymphocytic Leukemia that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of): Physician/Medical Colitis use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy page 2 should be detached for in the past 12 months? 1 ☐ Yes 2 🖾 No Day 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 1 ☐ Yes 2 ☑ No 2**X** No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA Medical Certification: To 1 Trnpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No investigation the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide TC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State

31. Date filed (Month,

20

Registrar DHMH 17 Rev 1/2001 Petek Donmez MD 11119 Rockville Pike #401 Rockville MD 20852 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DO62999

May 11, 2008

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amended #'s 15,16a,16b Per FH, gc 2 Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) 0,2 1610 **Physician** 05 Elizabeth Francis Gonzalez /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Neme (If not institution, give street end number) Examiner Prince George's Cheverly Prince George's Hospital Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex **Funeral** Months Days 1□M 218 F Cheverly, MD 48 5/2/2008 Director none Usual Residence of Decedent 10d. Inside City Limits death with the Meryland 10c. City, Town or Location 10a Stete 10b. County permit. Peges 1 and 2 should be filed within 72 hours efter death with the Merylen Depertment of Health end Mentel Hygiene. Important: if item 27 ie marked other then "naturel", or items 23s or 28s-f show any injury or other treumstic event, the Medical Examinat must be notified as 1 X Yes 2 □ No Directo Prince George's Hyattsville MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number Hyattsville U.S.A. Funeral 2201 Guilford #302 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Meritel Status 1 ☑ Never Married 2 ☐ Married 1⊠Yes 2□No *Specify:* Guatemal*a*n Specify: Biracial ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) none Elementery/Secondary (0-12) College (1-4or 5+) N/A none N/A none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Angela Gonzalez Dalford Francis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2201 Guilford Rd. #302, Hyattsville, MD 20783 Dalford Francis, Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 5/9/08 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signeture of Funeral Service Licensee 22. Name end Address of Facility 4739 Baltimore Ave. Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) TRISOMY - 18

Due to (or es a consequence of): /Medical Examiner Examiner EXTREVE PREMATURITY anding physiclen end use es the buriel-transit Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last DISTASE CONGENITAL Physician/Medicai Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tor: After this certificate hes been signed by the other time the funeral director, pege 2 should be deteched 1 Yes 2 No 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 XNo 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 🖾 ER/Outpatient 3 ☐ DOA ဥ 1 ☐ Yes 2 No 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician: nours efter deeth.

nerel Director: Af

filled in by the fu To the Hospital of within 24 hours of To the Funerel Completely filled

3altimore, Maryland 21215-0020

SC

29a. Certifier

(Check only one)

29b. Signature end title of certifier

edicai

State

Registrar

mennur Abedm

29c. License number 28189

CHEVERLY

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 08

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

HOSPITAL DRIVE

31. Dete filed (Month, Day, Year) MAY 1 3 2008

|            |  |                | 1 - For<br>State<br>Registrar  | State of  | Marylan  |                             | artment<br>rtificate                    |                                  |                             | and Me                                  |                               | jiene<br>eg. No.         | 2008                 | B. 17062  |
|------------|--|----------------|--|---|--|-----------------------------|---|----------------------------------|-----------------------------|---|-------------------------------|--------------------------|----------------------|---|
| ~2         | Physici  | an             | Decedent's Name (First, Middle   | e, Last)  |  |                             |   |                                  |                             | 2                                       | . Date of Dea<br>Month        | Day                      | Year                 | 3. Time of Death                                  |
| 1          | /Medi  |                | LAURA  4a. Facility Name (If not institution                                       |   | ORGE   |                             | 4b. City, 1                             | Fown, or                         | Location o                  | of Death                                | MAY                           | 5,<br>4c. C              | 2008<br>ounty of Dea | 2311  |
| 7          | LXaIIII  | iei            | LAUREL REGION  |   |  |                             |   | L                                | AUREL                       |   |                               |                          |                      | GEORGE'S  |
|            | Funeral<br>Director  |                | 5. Social Security Number  | 6. Sex<br>1 ☐ M 2 🗽 F                                 | 7. Age (In yrs.                                  | last birthday)<br>Yrs.      | If Under<br>Months                      | 1 Year<br>Days                   | If Under:<br>Hours          | Min.                                    | Date of Birth<br>(Month, Day  | , Year)                  | C                    | thplace (State or Foreign<br>ountry)              |
|            | p  |                | 216-29-5830<br>Usual Residence of Decedent   |   | 100  |                             |   |                                  |                             | M;                                      | arch 1                        | 5 190                    | )8   L.              | iberia  |
|            | show   | j.             | 10a. State 10b. County   |   | 10c. City  | y, Town or Lo               |   |                                  |                             |   |                               |                          |                      | 10d. Inside City Limits 1X Yes 2 No               |
|            | the N<br>28a-f   | Director       | Md. Prince 10e. Street and Number  | George's  |  |                             | Lar.                                    | ham<br>Code                      |                             |   | 1                             | 0g. Citize               | n of What C          |   |
|            | h with<br>23a or<br>st be  | al Di          | 5453 Whitfie   | ld Chapel   | Road   |                             |   | 207                              | 06                          |   |                               |                          | Libe                 | ria   |
|            | ems ar mu  | Funeral        | 11. Marital Status   |   | dent Ever in U.                                  | S. 13.                      | Was Deced                               |                                  |                             | gin? (Specif                            | fy Yes or No-<br>can, etc.)   | 14                       |                      | erican Indian,                                    |
| 980        | be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at   | by             | 1 □ Never Married 2 □ Man<br>3 🛣 Widowed 4 □ Divorced                              |   | 2 <b>∑</b> No<br>e                               |                             | 1 ☐ Yes 2                               |                                  | Specify:                    | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ,,                            | s                        | pecify:              | lack  |
| 21215-0036 | nin 72 hi<br>r.<br>n "natu<br>Medical  | Completed      | 15. Deceden<br>(Specify only highe<br>Elementary/Secondary (0-12)                  | t's Education<br>st grade completed)<br>College (1    | · Aor 5 L  | 16a. Dece<br>(Give<br>life. | dent's Usua<br>kind of wor<br>DO NOT us | l Occup<br>k done d<br>e retired | ation<br>during mos<br>()   | t of working                            |                               | 16b. Kind                | of Business          | s/Industry  |
| 212        | filed within Hygiene.  Hygiene.  other than " ent, the Mec   | Com            | 12th   | College (1  |  |                             | Ι                                       | ome                              | stic                        |   |                               |                          | Domes                | tic   |
| Maryland   | 2 should be filed<br>and Mental Hygir<br>is marked other<br>aumatic event, tl  | Be             | 17. Father's Name (First, Middle,  | •   |  |                             |   |                                  | 18. Mothe                   | er's Name (/                            | First, Middle,                | Maiden S                 | urname)              |   |
| Z<br>Sa    | should be ind Mental ind marked o  | 2              | Johnny Barnard  19a. Informant's Name/Relations                                    |   |  | 405 \$4-10                  |   | /04===4                          |                             |   | gusta                         |                          |                      | 7.0.1   |
| Ma         | s 1 and 2 should<br>f Health and Men<br>Item 27 is marke<br>other traumatic  |                | Edward Hall  |   |  |                             | whitf                                   |                                  |                             |   | Route Numbe                   | nham,                    | _                    | 20706   |
| ā,         | s 1 and 3<br>f Health<br>Item 27<br>other tra  |                | 20a. Method of Disposition   | 7 5011  | 20b. F   | Place of Disponentery, cre  |   |                                  |                             | Dat Dat                                 |                               |                          |                      | r Town, State                                     |
| E O        | 0 0  |                | 1X Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S                               |   | State  | enewy, cre<br>e of I        |   |                                  | :                           | 5-24-0                                  | na l                          | Si                       | ilver                | Spring, Md.                                       |
| Baltimore, | permit. Pag<br>Department<br>Important: I<br>any injury o  |                | 21. Signature of Funeral Service   | Licensee  | h  | 1 2                         | 2. Name and                             | d Addres                         | ss of Facilit               | ty Cap                                  | itol Ma                       | ortua                    | ary, I               | nc.<br>0002                                       |
|            | - 8  |                | 23a. Pan 1. Enter the diseas , p<br>shock, or heart failure. List                  | complications that c                                  | aused the deat                                   |                             |   |                                  |                             |   |                               |                          | DC Z                 | Approximate<br>Interval Between                   |
| 1          | Physician  |                | Immediate Cause (Final disease or condition  |   | ZHEIMEF  | -                           |   |                                  |                             |   |                               |                          |                      | Onset and Death                                   |
| 7          | /Medical<br>Examiner   |                | resulting in death)  | ol.   | or as a conseq                                   |                             |   |                                  |                             |   |                               |                          |                      |   |
|            |  | je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | b   | or as a conseq                                   | uence of):                  |   |                                  |                             |   |                               |                          |                      |   |
| 34         | uted<br>d<br>ansit   | Examiner       | cause. Enter Underlying<br>Cause (Disease of injury<br>that initiated events       | •   |  |                             |   |                                  |                             |   |                               |                          |                      | 1   |
| ,0         | be executed<br>sician and<br>burial-transit  |                | resulting in death) Last   | Due to (  | or as a conseq                                   | uence of):                  |   |                                  |                             |   | -                             |                          |                      |   |
| 68760,     | cate b   | dical          |  | d   |  |                             |   |                                  |                             |   |                               |                          |                      |   |
| Box 6      | death certifical<br>attending phy<br>i for use as th   | //Me           | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, out                                      | come pf pregna                                   | ancy                        |   |                                  |                             |   |                               | 23                       | 3d. Date of de       | elivery   |
| P.O. B     | The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Med  | in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown                            |   | irth 2 □ Feta<br>ant at time of d<br>own         |                             | ⊒Ectopic pre<br>⊒ Other (spe            |                                  | -                           | <u> </u>                                |                               |                          | Month                | Day Year  |
|            | that in the property of the pr |                | Part II. Other significant conditi   | ons contributing to de                                | eath but not res                                 | ulting in the u             | nderlying ca                            | ause giv                         | en in Part I                |   | 23e. Did to                   | bacco us                 | e contribute t       | to the cause of death?                            |
| Records,   | w requires<br>been sign<br>should be   | ed by          |  |   | ··   |                             |   |                                  |                             |   | 1 □ Y                         | es 30                    | No 3∏F               | Probably 4 Unknown                                |
| ဗင္ပ       | e law requ<br>has been<br>je 2 should  | Completed      |  |   |  |                             |   |                                  |                             |   | 24a. Was a                    |                          | 24b. Were a          | autopsy findings available completion of cause of |
| <u>=</u>   |  | Son            |  |   |  |                             |   |                                  |                             |   | perfor                        | med?<br>2√ No            | death?<br>1 ☐ Ye     | ·   |
| Vital      | Physician: Th<br>this certificate<br>al director, pag  | Be             | 25. Was case referred to medica examiner?  | Hospital:   |  |                             |   | Oth                              |                             | e of Death (                            | Check only o                  | ne)                      |                      |   |
| ō          |  | ۲ <u>.</u>     | 1 Yes 2 No 27. Manner of Death   | 28a. Date   | npatient 2 🗍                                     | ER/Outpatie                 |   | ^                                | 4 L <b>X</b> INL            |   | e 5 Resid                     |                          |                      | ecify)  |
| ion        | Attending Phradeng Phradeng. r death. ector: After the funeral   | ation          | 1 Matural 5 ☐ Pendir<br>2 ☐ Accident investi                                       | ig (Moni  | th, Day Year)                                    | Injury                      | М                                       | 8c. Injur<br>Worl<br>1 □         | k?<br>Yes 2□                |   |                               | o.,,,                    | 00001100             |   |
| Division   |  | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ                                       | inad   28e. Place                                     | of injury - At hong, etc. (Specif                | ome, farm, st               | reet, factory                           | , office                         |                             | 28                                      | f. Location (S<br>City or Tow | treet and<br>n, State)   | Number or F          | Rural Route Number,                               |
|            | To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in biggins.  | Medical C      | 29a. Certifier 1X Certifyin (Check only one)                                       | ng Physician: To the<br>Examiner: On the b<br>and man | best of my kno<br>asis of examina<br>ner stated. | owledge, deal               | th occurred anvestigation,              | at the tir                       | me, date ar<br>opinion, dea | nd place, an<br>ath occurred            | d due to the of               | cause(s) a<br>date and p | and manner a         | as stated.<br>ue to the cause(s)                  |
|            | To the within To the comple  | Me             | 29b. Signature and title of certific   |   |  |                             | 29c                                     | . Licens                         | e number                    |   |                               | 29d. Date                | signed (Mor          | nth, Day, Year)                                   |
|            | 1  |                | 1 / /mm  | 1 dh  | ic   | >                           |   | 00                               | 53235                       |   |                               | 5-7                      | 7-08                 |   |
|            | 0.00   |                | 30. Name and address of person   |   |  |                             |   |                                  | _                           |   |                               |                          |                      |   |
|            | St.  |                | Darryl Hill  |   | 35 Balt  |                             | Ave.                                    | La                               | urel,                       | Md.                                     |                               |                          |                      |   |
| - 10-6     | Sta  | ate            | 31. Date filed (Month, Day, Year,  | 32. H   | egistrar's Signa                                 | ature _                     |   |                                  |                             |   |                               |                          |                      |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 7:00 P M Gilliss Geraldine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner KUXTON DENTON HealthCare CAROLINE If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan 8 1917 Birthplace (State or Foreign Country) **Funeral** Min. 215-10-6259 1 □ M 2 💢 F Months Davs Hours Director MARYLAND Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No MD AroliNe Funeral Director DENTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21629 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by If Yes, Give Year or Dates: 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Healthcare College (1-4or 5+) Elementary/Secondary (0-12) L.P.N. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ida 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 38 Clark St. 19952 HARRINGTON, DE CHENN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CAPITOI Crematory 5/15/08 DOVER, DE 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
MOORE FUNDER HEME and plf/ ONE SECOND ST. 12 5. DENTON, MD 21629 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ONTH /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 this certificate has been signed by the attending physician ral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ \*PERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? (es 2) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D0053094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INBOLD, MD 321 BLOOMING DALS AUE FEDERALYBURG State

Registrar

|   |                | for State of I   | •  | epartment of F<br>Certificate of I                     |  |                                  | liene<br>eg. No. 2008        | 3 17064  |
|---|----------------|--|--|--|--|----------------------------------|------------------------------|--|
|   |                | Decedent's Name (First, Middle, Last)  |  |  | 7  | 2. Date of Deat                  | th                           | 3. Time of Death                                 |
| Physici<br>/Medio   |                | Michael Joseph G   | i11                                      |  |  | Month<br>Mav                     | Day Year 12 2008             | 4.4  |
| Examir  |                | 4a. Facility Name (If not institution, give street and number  |  | 4b. City, Town, o                                      | Location of Death                            |                                  | 4c. County of Dea            |  |
| ar and a second   |                | 4498 Willowtree Drive  |  | derick   |  |                                  |                              |  |
| Funeral   |                | 1 N 1 2 T E  | Age (In yrs. last birth                  | Months Days  | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day  | Year) 9. Bit                 | thplace (State or Foreign ountry)                |
| Director  |                | 215-50-1805 Usual Residence of Decedent  | 59 Y                                     | 15.  |  | August 1                         | .0,1948 N                    | Maryland   |
| dand<br>ow  |                | 10a. State 10b. County   | 10c. City, Town of                       | or Location  |  |                                  |                              | 10d. Inside City Limits                          |
| Mary<br>a-f sh  | ţo             | Maryland Frederick   |  | Middletown   | า  |                                  |                              | 1 ☐ Yes 2 🖾 No                                   |
| h the   | Director       | 10e. Street and Number   |  | 10f. Zip Code  |  | 1                                | 0g. Citizen of What C        | ountry?  |
| th wit  |                | 4498 Willowtree Drive  |  |  | 21769  |                                  | United St                    | ates   |
| r dea   | Funeral        | 11. Marital Status 12. Was Decede Armed Force  |  | 13. Was Decedent of H<br>If Yes, specify Cuba          | lispanic Origin? (Spo<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.) | 14. Race - Am<br>Black, Whi  |  |
| 72 hours after death with the Maryland 72 hours after death with the Maryland instural", or Items 23a or 28a-f show deal Evaniner must be notified at   | by Fi          | 1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 the street of the  |  | 1 ☐Yes 2 ☑ No  | Specify:                                     |                                  | Specify:                     | White  |
| hour<br>tural   | ed b           | 3 ☐ Widowed 4 ☐ Divorced Year or Date  |  | Decedent's Usual Occup                                 | ation  | T                                | 16b. Kind of Business        | /Industry  |
| in 72   | Completed      | (Specify only highest grade completed)   |  | Give kind of work done of the life. DO NOT use retired | during most of worki                         |                                  | TOD. TOTA OF ENGINESS        | andustry   |
| with giene  | mo             | Elementary/Secondary (0-12) College (1-40)   | or 5+)                                   | ernment Bus:   | DITECTO                                      |                                  | Securi                       | ty   |
| e filec   | Be C           | 17. Father's Name (First, Middle, Last)  |  |  | 18. Mother's Name                            | (First, Middle, I                | Maiden Surname)              |  |
| ld by enter the design of the | To E           | Ernest Joseph Gill   |  |  | Jean F                                       | iddler                           |                              |  |
| and and is ma   |                | 19a. Informant's Name/Relationship (Type. Print)   | 19b. N                                   | Mailing Address (Street                                | and Number or Rura                           | al Route Numbe                   | r, City or Town, State,      | Zip Code)  |
| ite, Widt vidal with Lizebooos<br>stand 2 should be filed within 72 hours after death with the Marylan<br>of Health and Tental Hygiene.<br>Item 27 is marked other that "natural", or Items 23a or 28a-f show<br>other traumatic event, the Wodies Examinating to multifulate   |                | Karen E. Gill / Wife   |  | 8 Willowtre  |  |                                  |                              |  |
| P T tof H   |                | 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from Sta   | 20b. Place of D<br>cemetery,             | Disposition (Name of crematory or other place          | (e) May                                      | 13,                              | 20c. Location - City of      | Town, State                                      |
| t. Par<br>rtmen<br>rtant:   |                | 4 ☐ Donation 5 ☐ Other (Specify)   |  | er Cremator  | y   20                                       | 008   F                          | rederick,                    |  |
| partitione, inc<br>permit. Pages 1 and 2 s<br>Department of Health a<br>Important: If item 27 is<br>any injury or other trau  |                | 21. Signature of Funeral Service Licensee  |  |  |  |                                  | neral Home                   | es, P.A.<br>cyland 21702                         |
| _   |                | 23a. Part1. Enter the disease, or complications that cause   | sed the death. Do no                     | ·  |  |                                  |                              | Approximate                                      |
| Physician   | 61. a          | shock, or heart failure. List only one cause on each<br>Immediate Cause (Final   |  | Cancer of  | +h - Moust                                   | _                                |                              | Interval Between Onset and Death 14 Months       |
| /Medical  |                | disease or condition resulting in death)  Squat  | as a consequence of                      |  | the nout                                     | .1                               |                              | 14 MOILLIS                                       |
| Examiner  |                |  |  | ,  |  |                                  |                              |  |
| D +   | ner            | Sequentially list conditions, if any, leading to immediate  Cause Fund Interval a  | as a consequence of                      | ):   |  |                                  |                              |  |
| ecute<br>ind<br>transi  | Examiner       | Cause (Disease or injury that initiated events c.  |  |  |  |                                  |                              |  |
| cate be exophysician a  | Ě              | resulting in death) Last Due to (or  | as a consequence of                      | ):   |  |                                  |                              |  |
| ificate be executed<br>g physician and<br>ts the burial-transit   | edical         | d  |  |  |  |                                  |                              |  |
| eath certi  | M/M            | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes the second s |  |  |  |                                  | 23d. Date of de              | elivery  |
| d for   | Physician/M    | in the past 12 months?   | h 2 ☐ Fetal death<br>It at time of death | 3 ☐ Ectopic pregnanc<br>5 ☐ Other (specify) _          | у  |                                  | Month                        | Day Year   |
| res that the de<br>signed by the  | hys            | 9 ☐ Unknown 9 ☐ Unknow   | n  |  |  |                                  |                              |  |
| gned<br>gned  | by F           | Part II. Other significant conditions contributing to death  | n but not resulting in t                 | he underlying cause giv                                | en in Part I.                                |                                  | bacco use contribute         |  |
| w requir  |                |  |  |  |  | 1 🗆 Y                            | es 21⊠No 3∏F                 | Probably 4 ☐ Unknown                             |
| e law r<br>has be   | Completed      |  |  |  |  | 24a. Was a                       |                              | utopsy findings available completion of cause of |
| The   | Sol            |  |  |  |  | perform                          | med? death?<br>2 ☑ No 1 ☐ Ye | •  |
| cian;<br>certific   | Be             | 25. Was case referred to medical examiner?   |  | l ou   | 26. Place of Death                           | n (Check only on                 | ne)                          |  |
| Physi<br>this c   | ၉              |  | atient 2 ER/Outp                         |  | 4 LI Nursing Ho                              |                                  | ence 6 Other (Sp             | ecify)   |
| ding Physician: The land After this certificate hit funeral director, page  | ion            | - Chang  | njury 28b. Tir<br><i>Day, Year)</i> Inji | ury Wor  | y at<br>k?<br>Yes 2 □ No                     | 28d. Describe h                  | ow injury occurred           |  |
| tten<br>death<br>ctor:<br>y the   | lical          | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of   | Injury - At home, farm                   | n, street, factory, office                             |  | 28f. Location /S                 | treet and Number or F        | Rural Route Number                               |
| after Direction by din by   | Certification: | 4 Homicide determined building,  | etc. (Specify)                           | .,,,,,,  |  | City or Tow                      |                              | ara mode manipor,                                |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  | edical C       | 29a. Certifier  (Check only one)  1 Certifying Physician: To the base and manner and manner  | s of examination and                     |  |  |                                  |                              |  |
| To the within To the Somple   | Med            | 29b. Signature and title of certifier  |  | 29c. Licens  | e number                                     | 2                                | 29d. Date signed (Mon        | th, Day, Year)                                   |
|   |                | * *  UU   -  |  | Dog  | 139847                                       |                                  | 5/12/4                       | 25   |
| 15  |                | 30. Name and address of person who completed cause of  | of death (Item 23a) (T                   | ype, Print)  |  |                                  | - [                          |  |
| . —   |                | Robert Kirk Jackson, M.D   |  | nas Johnson  | Drive 1                                      | Frederic                         | k, Marylar                   | d 21702  |
| Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) 32. Regi   | strar's Signature                        | & Andre  | Ŷ  |                                  |                              |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Z:35 AM **Physician** TEATHERS 2008 ERLINE DAIL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FRESERICK FREDERICK CFUTER LIVING 9. Birthplace (State or Foreign Country) South If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT 27, 19 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Days Min. 1 M 2 F 249-40-235 27,1919 CAROLINA Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 ☐ No Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f sh any injury or other traumatic event, the Medical Examiner must <u>be notified</u> i REDERICK Funeral Director MO WOODSBORD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 232 CARNELL 4. 5. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 12 No Specify: BLACK Saltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) PRIVATE Elementary/Secondary (0-12) College (1-4or 5+) amastic AMILLES 6 H 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SARAIH EMENT P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHERRY -UL TON (DAUGHTER) 21798 CORNELL DR. Woodsbaro MD. 20c. Location - City or Town, State
SOUTH CAROLINA Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury of MAY 5, 2008 MACONDIA com. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility GARY L. Rolling 21. Signat re if Funeral Servi plicensee Ms. 2/10/ 100 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. Immediate Cause (Final disease or condition resulting in death) evephera Physician /Medical Due to (or as a consequence of): Examiner em entre if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-trai Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 ☐ Other (specify) P.0. ed by the a detached f 9□Unknown 9 ☐ Unknown signed by the Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autons performe Division or Vital Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 🗌 Yes within 24 hours after deam.

To the Funeral Director: After this of မ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ö Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

State Registrar

29b. Signature and title of certifier

30. Name and ad

Heimen

31. Date filed (Month, Day, Year)

ND

2008

2

MAY

ss of person who completed cause of death (Item 23a) (Type, Princ N Shah 450 Th Mas 10

32. Regist

29c. License number

lohnson

00664

Drive

tredevil

29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 2008 **Physician** Clay May 11, 2:54 P M Robert Gumphrey, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11219 Wabash Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. 1 M 2 □ F 82 579-18-7041 Director 02/16/1926 D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show edical Examiner must be notifled at Director 1 ☐ Yes 2 XNo MD Cumberland Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11219 Wabash Street 21502 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No þ Specify: Specify: 3 Widowed 4 □ Divorced WWTT White Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within.
Department of Health and Mental Hygier important: if item 27 is marked other than any injury or other trailmath. Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver State Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Edward Gumphrey 0ra Letha ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela C. Rose / Daughter 11219 Wabash Street, Cumberland, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans'CemRocky Gap 05/14/2008 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Alams Family Funeral Rome, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final nds **Physician** brouter disease or condition resulting in death) nn /Medical Due to (or as a consequence of) Di3cas Examiner Sequentially list conditions, if any, basing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical the attending IF FEMALE for use 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐Yes 2☐No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð Qu scas 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown funeral director, r age 2 should Completed een 24a Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed?
Yes 22000 death? 1 ☐ Yes certificate 2 □ No 1∐ Yes Division or Vital Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 2 ☐ ER/Outpatient 3 ☐ DOA P 1 | Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending ¶ T⊠Natural 5 | Pending To the hospius. ... within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D21244 May 12, 2008 5 + 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

n M State

State 31. Date filed (Month, Day, Year)
Registrar 32008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.-3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month 1.000 **Physician** 2008 05 tami /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Bal TOM (VVIA Timur R If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Moath, Day)
Months Days Hours Min. (Moath, Day) Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number 6. Sex Vear Funeral Months 10 M 2 F 577 - 04 - 5670 Director Usual Residence of Decedent 10d. Inside City Limits with the Manyland 10c. City, Town or Location 10a. State item 27 is marked other than "neturel", or items 23a or 28e-f show other treumetic event, the Medical Examiner must be rigitled at Beltimure 1 X Yes 2 No Baltimure MY al Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2122 al permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "neturel", or items 23a any injury or other treumetic event, It is Medical Examiner mass\*\* Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Black Specify timore, Maryland 21215-0036 þ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland Highway Maintenance 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jacqueline Johnson Harri James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21229 743 Yale Ave. Baltimore, Md. James Hamilton /Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metropolitan 5/9/2008 Alexandria, Va. <sup>1</sup> 4 □ Donation \ 5 □ Other (Specify) 21. Signature of Funeral Service License 2. Name and Address of Facility Alexander S. Pope P.A. 5538 Mariboro Pikė/Forestville, Md. 20747 Approximate Interval Between Onset and Death 23a. Part Ener the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listonly one cause on each line. Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, by Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day Year in the past 12 months? for 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.0. detached 9 Tinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🖾 № Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 2 PNo 1 Yes To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Pinatural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 ☐ Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of pay knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 140062638 00

Registrar

0

State

1600 W. Mr. Royal Ave. Baltimore MD 21217

30. If me and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)
MAY 1 3 2008

0.0

32. Registrar's Signature

|            |  | 4              | For State Registrar   | State   | of Marylar  |                                    | artment of H                                | lealth and N<br>Death                       |  | ene (                       | 08                          | 17069  |  |
|------------|--|----------------|---|---|---|------------------------------------|---|---|--|-----------------------------|-----------------------------|--|--|
|            |  |                | Decedent's Name (First, Midd  | lle, Last)                                    |   |                                    |   |   | 2. Date of Death   |                             | Year                        | 3. Time of Death                                   |  |
|            | Physicia<br>/Medic   | _              | Cathlin   | Rose H  | lanson  |                                    |   |   | Month 5  | 6.2/                        |                             |  |  |
|            | Examin   |                | 4a. Facility Name (If not institution   | on, give street and no                        | umber)  |                                    |   | r Location of Death                         | 200  | 4c. County of Death         |                             |  |  |
|            |  |                | Heartland H   | ealthcar                                      | ce Cent   | ter                                | Hyatts                                      |   |  | Prin                        |                             | eorges   |  |
|            | Funeral  |                | 5. Social Security Number   | 6. Sex<br>1 ☐ M 2 🔀 F                         |   | . last birthday)                   | If Under 1 Year<br>Months Days              | If Under 24 Hrs.<br>Hours Min.              | 8. Date of Birth (Month, Day,  |                             | 9. Birthpi<br>Coun          | lace (State or Foreign ltry)                       |  |
|            | Director   |                | 578-78-4348 Usual Residence of Decedent   | 10.11.24                                      | 74  | Yrs.                               |   |   | 2/24/1   | 934                         | Jama                        | ica  |  |
|            | and we   | -              | 10a. State 10b. County  | у   | 10c. C  | ity, Town or Lo                    | cation                                      |   |  |                             | 1                           | 0d. Inside City Limits                             |  |
|            | Mary<br>f she  | ō              | Md. Prin  | ce Georg                                      | es Hy   | attsv                              | ille  |   |  |                             |                             | 1 ☐ Yes 2X No                                      |  |
|            | the rout   | Director       | 10e. Street and Number  |   |   |                                    | 10f. Zip Code                               |   | 10   | g. Citizen of               | What Coun                   | itry?  |  |
|            | 3a ol  | <u>-</u>       | 6912 23rd   | Ave.  |   |                                    |   | 20783                                       | Į  | J.S.A                       | •                           |  |  |
|            | deed<br>Fm   | Funeral        | 11. Marital Status  | 12. Was De                                    | cedent Ever in U                                    | U.S. 13.                           | Was Decedent of H                           | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)   |                             | ce - Americ                 |  |  |
| 9          | or its   | F              | 1 Never Married 2 Ma  | rnied 1 ☐ Yes                                 | 2 X No<br>iive                                      |                                    | 1 ☐ Yes 2X No                               |   |  | Spec                        | y: bl                       | ack  |  |
| 8          | within 72 hours after deeth with the Maryland<br>ene.<br>then "naturel", or Items 23a or 28a-f show<br>the Medical Examinar must be notified at  | d by           | 3 Widowed 4 Divorce   |   | Dates:  | 16a Doce                           | dent's Usual Occup                          | ation                                       |  | l6b. Kind of I              | Business/Inc                | dustry   |  |
| 21215-0036 | n 72   | Completed      | (Specify only high  | nt's Education<br>est grade completed         |   | (Give                              | kind of work done<br>DO NOT use retired     | during most of world)                       | king   |                             |                             | ,  |  |
| 7          | with<br>iene.  | E              | Elementary/Secondary (0-12)   | College                                       | (1-4or 5+)  | Hous                               | ekeeper                                     |   |  | home                        | <u> </u>                    |  |  |
|            | hould be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other then "naturel", or Items 23a or 28a-f show marked other then "naturel", or Items 23a or 28a-f show matic event, the Medical Examinar must be notified at | 0              | 17. Father's Name (First, Middle  | , Last)                                       |   |                                    |   | 18. Mother's Nam                            | ne (First, Middle, M   | laiden Suma                 | me)                         |  |  |
| <u>lar</u> | should be<br>and Mental<br>s marked o  | To B           | Joclyn Han  | nson  |   |                                    |   | Irene                                       |  |                             |                             |  |  |
| Maryland   | 2 sho<br>and 1<br>is mu  |                | 19a. Informant's Name/Relation  |   |   |                                    |   | and Number or Ru                            |  |                             |                             |  |  |
|            | and<br>ealth<br>m 27<br>har tr   |                | Beverly O. F  | Rowe/dau                                      |   | 6912                               | 23rd  | Ave. Hy                                     |  | Le, N                       |                             |  |  |
| Baltimore, | ges 1<br>if of F<br>if ite<br>or of  |                | 20a. Method of Disposition<br>1   Burial 2 □ Cremation                                    |   | 01.1  | cemetery, crei                     | natory`or other plac                        | on 5/17                                     |  | Adelp                       |                             |  |  |
| Ë          | t. Pa<br>rtmen<br>rtant:<br>njury  |                | 4 Donation 5 Other (  |   | Ge,   | _                                  |   | ess of Facility Ur                          |  |                             |                             |  |  |
| Ba         | permit. Pages 1 and 2 should by Depertment of Health and Menta Important: If Item 27 is marked eny injury or other traumatic evone.  |                | ) may   | Varlin  |   |                                    |   |   |  |                             |                             | DC 20011   |  |
|            |  |                | 23a. Part1. Enter the disease, of shock, or heart failure. Lis                            | or complications that<br>st only one cause on | caused the dea                                      | ath. Do not ent                    | er the mode of dyin                         | ng, such as cardiac                         | or respiratory arre  | est,                        |                             | Approximate<br>Interval Between<br>Onset and Death |  |
|            | Physician  |                | Immediate Cause (Final disease or condition   | _a C  | ARDI  | opul                               | NoveAR                                      | Y AR  | KEST   |                             |                             | 0.100. 2.10 0.02.11                                |  |
|            | /Medical<br>Examiner   |                | resulting in death)   | Due to  | o (or as a conse                                    | equence of):                       | 11146                                       | ADI TIE                                     | Total Contract of the Contract |                             |                             |  |  |
|            |  | -              | Sequentially list conditions, if any, leading to immediate                                | b. Due to                                     | o (or as a conse                                    | quence of):                        | 11 119                                      | Mollic                                      | 77.1   |                             |                             |  |  |
|            | nsit   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events  c. #YFERTERLSiony |   |   |                                    |   |   |  |                             |                             |  |  |
| ó          | exection and rial-tra  | Еха            | resulting in death) Last  | Due to  | o (or as a conse                                    | equence of):                       |   |   |  |                             |                             |  |  |
| 8760,      | icate be executed<br>physicien and<br>s the burial-transit   | Icai           |   | d   |   |                                    |   |   |  |                             |                             |  |  |
| 9          | death certifica<br>e attending ph<br>id for use as t   | Physician/Med  | IF FEMALE:  | 00- 14  |   |                                    |   |   |  |                             |                             |  |  |
| Вох        | aath certific<br>attending p<br>for use as   | lan/           | 23b. Was decedent pregnant in the past 12 months?   | 1 ☐ Live                                      | outcome of prego<br>birth 2 Per<br>gnant at time of | tal death 3                        | Ectopic pregnanc Other (specify)            | у   |  |                             | ate of delive<br>fonth      | ery<br>Day Year                                    |  |
| P.0.       |  | yslc           | 1 ☐ Yes 2 ☐No<br>9 ☐ Unknown  | 9□ Unk  |   | dealii 3L                          | _ Other (specify) _                         |   |  |                             |                             |  |  |
|            | that t   |                | Part II. Other significant condi  | tions contributing to                         | death but not re                                    | esulting in the u                  | nderlying cause giv                         | ven in Part I.                              | 23e. Did tob   | acco use co                 | ntribute to t               | he cause of death?                                 |  |
| rds        | quires<br>n sign   | ed by          | CEREBRI   | OVASCUL                                       | AR A  | CCIDE                              | 4   |   | 1 □ Ye   | s 2 M No                    | 3 Prot                      | bably 4 ∐Unknown                                   |  |
| Records,   | law requires that the<br>es been signed by th<br>2 should be detache   | Completed      |   |   |   |                                    |   |   | 24a. Was a   |                             | . Were auto                 | opsy findings available ompletion of cause of      |  |
| æ          | The age  | E              |   |   |   |                                    |   |   | perform  | ned?                        | death?                      |  |  |
| ital       | lician: T<br>certificel<br>rector, p   | BeC            | 25. Was case referred to medic examiner?  | al  |   |                                    |   | 26. Place of Dea                            | ath (Check only on   | e)                          |                             |  |  |
| of Vital   | Physician:<br>rthis certific<br>ral director,  | 2              | 1 ☐ Yes 25⊈No   | 1   |   | ☐ ER/Outpatie                      | II 3 DOA                                    |   | lome 5 Reside  |                             |                             | (y)  |  |
|            | ng Pl  |                | 27. Manner of Death 1 ⊠Natural 5 □ Pend   | ing 28a. Dat                                  | e of Injury<br>onth, Day Year)                      | 28b. Time of<br>Injury             | Wo  |   | 28d. Describe ho   | w injury occ                | urred                       |  |  |
| sio        | Attending<br>ir death.<br>ector: After<br>by the fune  | cati           | 2 Accident inves  | tigation<br>d not be                          | an of Injune At                                     | hama farm of                       |   | ]Yes 2□No                                   | 28f Location (St   | reet and Nu                 | nher or Rur                 | al Route Number,                                   |  |
| Division   | al or Al<br>effer<br>i Direc<br>d in by  | Certification: | 4 ☐ Homicide deter  | mined 259. Pla                                | Iding, etc. (Spec                                   | cify)                              | reet, factory, office                       |   | City or Towr   | n, State)                   |                             |  |  |
|            | To the Hospital or Attending F<br>within 24 hours effer death.<br>To the Funerel Director: After<br>completely filled in by the funer  | ledical (      | 29a. Certifier 1 Certify (Check only one)   | ring Physicien: To t                          | he best of my ki<br>basis of examination            | nowledge, deat<br>nation and/or in | h occurred at the to<br>evestigation, in my | ime, date and place<br>opinion, death occu  | e, and due to the caured at the time, d  | ause(s) and<br>ate and plac | manner as s<br>e, and due t | stated.<br>to the cause(s)                         |  |
|            | omple  | Me             | 29b. Signature and title of certif  |   |   |                                    | 29c. Licen                                  | se number                                   | 2  | 9d. Date sig                | ned (Month,                 | Day, Year)   |  |
| )          | 7  |                | 1 Dars  | oks N   | 10  |                                    | 104   | 6529  |  | MAY                         | 8 =                         | 2608   |  |
|            | 10   |                | 30. Name and address of person  | on who completed ca                           | use of death (It                                    | em 23a) (Type                      | Print)                                      | m 0 10 c                                    | 1 ( ) ===  | <i>∞</i> 0 = 4 ¬            | AA                          | 2 . / 4 0 . 20                                     |  |
|            | AK.  |                | VICTOR OF   | MAINTE  | +52   | 1 A HA                             | e control                                   | MXKMI                                       | yktto  | BEL 7                       | NAK                         | J MAN TOHO   |  |
|            | Sta<br>Registi   |                | 31. Date file (A) (11 Day Year  | 008   | Registrar's Sig                                     | mature                             | 50  |   |  |                             |                             |  |  |
|            | 3.0  |                |   |   | -   |                                    |   |   |  |                             |                             |  |  |

DHMH 17 Rev 1/2001

08-03251 John Patrick Hill

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day April 27, 2008 2035 hrs **Medical Examiner** JOHN PATRICK HILL 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Caroline Route 404 & Gay Street Denton 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** oreign Months Days Hours Director JUN 12,1968 Country) D.C. 1 X M 2 F 39 Yrs 215-94-8133 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 Yes 2 X No s 23a or 28a-f show e notified at once. DENTON CAROLINE Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21629 10771 GREENSBORO RD. Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death 1 2 X Married Never Married 0 Yes WHITE Pages 1 and 2 should be filed within 72 hours after Yes 2 X No specify: Specify: 3 Widowed 4 Divorced If Yes, Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) QUEEN ANNE'S COUNTY Elementary/Secondary (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical or other traumatic event MD 21215-0036 PUBLIC SCHOOLS SCHOOL BUS DRIVER 0 12 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JOHN ALVIN HILL PATRICIA HOFFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10771 GREENSBORO RD., DENTON, MD 21629 A.J. HILL/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State CHESAPEAKE CREMATION CTR 5/6/2008 STEVENSVILLE, MD Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 2160 MERCERO 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death a. Multiple Injuries immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Live birth Fetal death past 12 months Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o \$ Yes 2 No 3 Probably 4 ✔ Unknown σ. Completed Division of Vital Records, 24b. Were autopsy findings available 24a, Was an prior to completion of cause of autopsy has performed? ✓ Yes 2 No ✓ Yes 2 No certificate 26. Place of Death (Check only one) the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical Be examiner? Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 Ves Certification: To 28a. Date of Injury After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject driver of vehicle in motor vehicle Apr 27, 2008 2030 hrs 1 Natural Yes 2 V No Pending Director: accident 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) Route 404 & Gay Street, Denton, Md. Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier **OCME** O.C.M.E. April 28, 2008 W fredor JA Name and address of person who completed cause of seath (Item 23a) 6 Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M. King, Jr., MD. Registrar's Signature 31. Date filed MAN, DO, 2ar)2008 State Registra

requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending death.

1 and 2 should

Pages 1

within 24 hours after death

To the Funeral Director:
completely filled in by the

DHMH 17 Rev 1/2001

State Registrar

Medical

MY 0 2 Christina Turner, M.D.

Year)

29c. License number 066371

📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2008

21601

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

219 S. Washington St. Easton, MD rar's Signature

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day,

**DHMH 17 Rev 1/2001 OCME 2006** 

Registra

**OCME** 

20

within 24

WOOD, 501 DUTCHMANS LANE, EASTON, MD 21601 WILLIAM H. M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

(Check only

29b. Signature and title of certifie

29c. License number

08

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8:15P M Sandra J. Lorenz Physician May 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 111 Carolin Court Preston Caroline 8. Date of Birth (Month, Day, Year)
Aug. 9,1940 Pennsylvania Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Months Days Hours 1 ☐ M 2 🔀 F 67 Yrs. 197-34-2644 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County 1X Yes 2 No Caroline Preston Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code filed within 72 hours after death with 111 Carolin Court 21655 "natural", or Items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 1 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home ş Homemaker 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If item 27 is marked othr any injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Claire Losse John Rose 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert H. Lorenz/Spouse P.O. Box 148, Preston, MD 21655 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Junior Order Cemeter 05/17/08 Preston, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Framptom Funeral Home, 21. Signature of Funeral Service Licensee Muhael 216 N. Main St., Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) requires that the death certificate be executed Exami burial-trar and Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year for in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by d be detach 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 ☐ Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s 1□ Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signa cause of death (Item 23a) (Type, Print) 30. Name and address of person Year! legistrar's Signature State Registrar

DHMH 17 Rev 1/2001

|   | 1 - State Registrar  1. Decedent's Name (First, Middle, La   | est)  | Ce                              | rtificate of   | Dealli                           | 2. Date of Deat                       | g. No.                                     | 3. Time of Dear     |  |  |
|---|--|---|---------------------------------|--|----------------------------------|---------------------------------------|--|---------------------|--|--|
|   | Carrie Lankford  |   |                                 |  |                                  | Month<br>May 8                        | Day 2008 Year                              | 11:25 P             |  |  |
|   | 4a. Facility Name (If not institution, give  | re street and number)   |                                 | 4b. City, Town, o  | or Location of Deat              |                                       | 4c. County of Death                        |                     |  |  |
|   | 6898 Lois Avenue   |   |                                 | Salisl   | oury                             |                                       | Wicomico                                   | )                   |  |  |
|   |  | Was all a   | . last birthday)                | If Under 1 Year<br>Months Days   | If Under 24 Hrs<br>Hours Min.    |                                       | Year) 9. Birth                             | nplace (State or Fo |  |  |
|   | 254-36-4512  | 1 M 2 H 80  | Yrs.                            |  |                                  | Nov. 8,                               | 1927 Geo:                                  | rgia                |  |  |
|   | Usual Residence of Decedent  10a. State 10b. County  | 10c. C  | ity, Town or Lo                 | ocation  |                                  |                                       |  | 10d. Inside City L  |  |  |
| ţō  | Maryland Wicomic   | 0   | Parso                           | nsburg   |                                  |                                       |  | 1 Tes 2             |  |  |
| irec  | 10e. Street and Number   |   |                                 | 10f. Zip Code  |                                  | 10                                    | g. Citizen of What Co                      | untry?              |  |  |
| aiD   | 33562 Old Ocean  | City Road   |                                 |  | 21849                            |                                       | USA  |                     |  |  |
| Iner  | 11. Marital Status   | 12. Was Decedent Ever in Armed Forces?  | U.S. 13.                        | Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto |                                  | Specify Yes or No-<br>to Rican, etc.) | 14. Race - Amer<br>Black, White            | nican Indian,       |  |  |
| Ž.  | 1 Never Married 2 Married  | 1 ☐ Yes 2 🕅 No<br>If Yes, Give  |                                 | 1 ☐ Yes 2 💆 No   | Specify:                         | ,                                     | Specify: Wh                                |                     |  |  |
| g<br>p  | 3 ☐ Widowed 4 ☒ Divorced  15. Decedent's E   | Year or Dates:  | 1 160 Dans                      | daatta Hawai Oaa   |                                  |                                       |  |                     |  |  |
| Siet  | (Specify only highest gr   | ade completed)  | (Give                           | dent's Usual Occup<br>kind of work done<br>DO NOT use retire                 | ation<br>during most of wo<br>d) | rking                                 | 16b. Kind of Business/I                    | naustry             |  |  |
| E   | Elementary/Secondary (0-12)  | College (1-4or 5+)  |                                 | Equipmen   |                                  |                                       | Poultry                                    |                     |  |  |
|   | 17. Father's Name (First, Middle, Last   | )   | 1                               |  |                                  | me (First, Middle, A                  |  |                     |  |  |
| 0   | Lola Lorenzo Lan   | kford   |                                 |  | Maggie                           | Pearson                               |  |                     |  |  |
|   | 19a. Informant's Name/Relationship   | Type, Print)  | 19b. Maili                      | ng Address (Street   | and Number or Ri                 | ural Route Number,                    | City or Town, State, Z                     | ip Code)            |  |  |
| 어른 하는 기계 전략 및 함께 기계 전 | Betty Baker/Comp   |   |                                 |  | an City                          | Road, Par                             | sonsburg,                                  | MD 21849            |  |  |
|   | 20a. Method of Disposition  1 \( \overline{\Omega} \) Burial 2 \( \overline{\Omega} \) Cremation 3   |   | Place of Dispo<br>cemetery, cre | osition (Name of<br>matory or other pla                                      | сө)                              | Date 2                                | 20c. Location - City or                    | Town, State         |  |  |
|   | 4 □Donation 5 □ Other (Speci   | (y) Spr   | inghill                         | Mem.Garde  | ns = 5/13                        | 3/2008 I                              | Hebron, Mar                                | yland               |  |  |
|   | 21. Signature of Funeral Service Lice  | sed Olas  | 7.                              | 2. Name and Addre  | ss of Facility                   | e. P. O.                              | Box 3171                                   |                     |  |  |
| - 1   | 23 art1. Enter the disease, or com   | guer  |                                 |  |                                  |                                       | Box 3171,<br>alisbury,                     | MD 21802            |  |  |
| 1. 1  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Due to (or as a consect.  Due to (or as a consect.  Due to (or as a consect.)              | quence of):                     |  |                                  |                                       |  |                     |  |  |
|   | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?   | d   | al death 3                      | ⊒Ectopic pregnanc  | ,                                |                                       | 23d. Date of deli                          | very<br>Day Yea     |  |  |
| nysic   | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown  | 4⊡Pregnant at time of<br>9⊡Unknown  | death 5                         | Other (specify) _  |                                  |                                       |  | ,                   |  |  |
| þ   | Part II. Other significant conditions  | contributing to death but not re  | sulting in the u                | inderlying cause giv   | ren in Part I.                   |                                       | acco use contribute to<br>s 2 ☐ No 3 ☐ Pro |                     |  |  |
| npie  |  |   |                                 |  |                                  | 24a. Was ar<br>autops                 | prior to c                                 | topsy findings ava  |  |  |
|   |  |   |                                 |  |                                  | perform<br>1 ☐ Yes 2                  |  | al No               |  |  |
| 00  | 25. Was case referred to medical examiner?   | Hospital:   |                                 | 10   | 05                               | ath Check only one                    |  | PAUGHTE             |  |  |
|   | 1 Yes 2 No 27. Mann of Death   | 1 ☐ Inpatient 2 ☐   | ER/Outpatier<br>28b. Time o     |  | 4 Li Nursing F                   | lome 5 ☐ Reside                       |  | W RESIDEN           |  |  |
| tion  | 1 Natural 5 ☐ Pending 2 ☐ Accident investigatio  | (Month, Day Year)   | Injury                          | Wo   | yat<br>k?<br>Yes 2 ∐No           | 28d. Describe ho                      | w anjury occurred                          |                     |  |  |
| Sertifica   | 3 Suicide 6 Could not be determined  | e   | home, farm, str                 |  |                                  | 28f. Location (Str<br>City or Town    | eet and Number or Ru<br>. State)           | ral Route Number    |  |  |
| -   | 29a. Certifier 1FCertifying Physician: To the best of my knowledge death occurred at the time date and place and due to the cause(s) and manner as stated  |   |                                 |  |                                  |                                       |  |                     |  |  |
| -53   | Harris and the second  | 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) |                                 |  |                                  |                                       |  |                     |  |  |
| -63   | 29b. Signature and title of certifier  | -   |                                 | 290. [108113   | e number                         | -                                     | _ /. /                                     | i, Day, Tear/       |  |  |
| -63   | 29b. Signature and title of certifier  | lust 1  | UP                              | 1  |                                  |                                       | 5/12/08                                    |                     |  |  |

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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 20,2008 J. Hallmann Maienza Beverly /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Lions Manor Nursing Home Cumberland | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jun 3, 1932 5. Social Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 356-24-3151 75 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Items 23a or 28a-f show ner must be notlfied at 1y⊡Yes 2 No MD Allegany Cumberland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 16116 Orchard Mews Drive SW Apt. 402 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. "natural", or iten 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 3altimore, Maryland 212 own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be t Health and Mental Alexander Charles Weber Kathryn Elizabeth (Meiche) Weber ို 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 14603 McGill Drive, SW Cumberland Pages 1 and 2 tment of Health a daughter Debbie Hagelin Department of Health Important: If item 27 any injury or other tr once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 N Burial 2 □ Cremation 3 □ Removal from State Florida National Cemetery 5/23/2008 Bushnell FL 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service on se 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Partf. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ohih Chronic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the buriat-trans Due to (or as a consequence of) Box 68760, Physician/Medical use as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown signed by ti Part II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Dicia 2 No 3 Probably 4 Unknown Completed page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has autopsy perform 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ို 1 🗌 Inpatient After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Certification: 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue Cumberland Smil 31. Date filed (Month. State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Connie 2008 Μ. Mitchell May 4. 8:10 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 1 Heights If Under 24 Hrs 600 Addison Road South Prince George's <u>Capitol</u> 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min. 1 M 2 F Director 579-28-4258 81 April 3, 1927 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1<sup>™</sup>Yes 2□No Capitol Heights Director Maryland Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 600 Addison Road South 20743 Funeral <u>United States</u> 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married African Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ 3 Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12 years Nurse unould be file alth and Mental Hway 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Caroline (Unknown) Winston Bright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 600 Addison Road South Capitol Heights, MD 20743 Joe B. Mitchell - Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Nat'l Mem PK May 12, 2008 Laurel, MD 21. Simulature of Fundal Survice 22 Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Part F. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Viabetes /Medical Due to (or as a consequence of): Examiner ortension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to ( s a consequence of): death certificate be executed ementa use as the burial-tran Due to (or as a consequence of) Box 68760, ed by the attending physician detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy death? 1 ☐ Yes 2□No I Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Medical Certification: To nours after death.

neral Director: After this y filled in by the funeral di this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

Branch Ave. Temple Hills Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nguyen

2008

MO

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death MONROE Day **Physician** 11:00 P M May 6. 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Thomas More Nursing Home Prince George's Hyattsville 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday, Days Hours 1 □ M 2 🖫 F Director South Carolina 94 1914 578-26-4628 Jan 31. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Items 23a or 28a-f shov ner must be notified at TX Yes 2 No Director District of Columbia Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20015 United States 5201 Connecticut Avenue, NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☑ No Black. ģ 3 Midowed 4 Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 years <u>Housekeeper</u> Private is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Effert Matthews Gertrude Harling ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 6512 Westview Lane Lanham, MD 20706 Merle Peebles - Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of I
Important: If it,
any injury or o
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) Harmony Memorial Park May 12, 2008 Landover, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 23a. Par 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ships, or heart failure. List only one cause on each line. Hypertensiv Due 1-12 a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🖺 No 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached f Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sig page 2 should b 1 | Yes 2 Info 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performe 1∐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) r 1 Dippatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 A Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide within 24 hours at To the Funeral D completely filled i 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D0051122 e of death (Item 23a) (Type, Print) 30. Name and address of person who comp VATNUM ST. NE WASh 1/60

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle, Last) Day Year Month **Physician** 3:40 A<sup>M</sup> 2008 May Sheila Muhammad Mashala /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Temple Hills 2116 Gaither Street If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months 1 □ M 2 X F 577-72-3554 56 Washington, DC Director July 26, 1951 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County "natural", or items 23a or 28a-f show idical Examiner must be notified at 1 Yes 2 No Director Prince George's Maryland Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2116 Gaither Street 20748 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indiar 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 10 years College (1-4or 5+) Homemaker Private permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James West Nannie Bolden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Abdul Alim Muhammad - Husband 2116 Gaither Street Temple Hills, MD 20748 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Lincoln Mem. Cemetery May 10, 2008 Suitland, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. 21 Si nature of Funeral Serv 4001 Benning Road, NE Washington, DC 20019 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Stomach Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. E. its Urber yill Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine death certificate be executed use as the burial-trar Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IE FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕅 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) detached 9□Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 : 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific pompletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 | Inpatient 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury Certification: (Month, Day Year) 1**₹** Natural 5 Pending investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a **To the Funeral L** 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State

1 3 2008 (ear)

29b. Signature and title of certifier

Wayne A.I. Frederick, M.D. 2041 Georgia Avenue, NW #4000 Washington, DC 20060 32. Redictrar's

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

29c. License number

MD30905

29d. Date signed (Month, Day, Year)

May 9, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** 5:15 P M 2008 4c. County of Death **ELLEN** MELTON /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 438 GERARD ST. #204 GAITHERSBURG MONTGOMERY 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Min 1 □ M 2 € F LIBERIA Director 218-35-0490 100 OCT. 31, 1907 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at another. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 A Yes 2 No MD MONTGOMERY Director GAITHERSBURG 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 438 GERARD ST.. #204 Funeral 20877 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Saltimore, Maryland 21215-0036 2 Specify: 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC DOMESTIC 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALEXANDER MARS ျှ CATHERINE BROWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 438 GERARD ST., MARIA SCOTT/DAUGHTER #204 GAITHERSBURG, MD. 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State tion Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) CHURCH\_CEMETERY 5/31/08 CALDWELL, LIBERTA f Funeral Service Licens 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WASH., D.C. 23a. Part1. Enter the disease, or complications that caused the death. If not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARREST /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MALNUTRITION Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran DEMENTIA Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Thesidence 6 Other (Specify) 1 ☐ Yes 2X No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 2 Accident 1 Yes 2 No after death.

Director: A
I in by the fu 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 27830 5/12/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

RAMBETH SHAKIR

31. Date filed (Month, Day,

MAY 1 3 2008

9019 SHADT GROVE CT. GAITHERSBURG.

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death

**Physician** /Medical Examiner

1 - For State Registrar

**Funeral** Director

ral", or items 23a or 28a-f show Examiner must be notified at "natural" the Medical filed within Hygiene. is marked other than traumatic event, and Mental permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra

21215-0036

**Baltimore, Maryland** 

HOWARD MULLIKIN

**Physician** /Medical Examiner

certificate be executed

Box 68760.

P.O.

Records,

or Vital

Division

lor A

burial-transi and iding physician the as atten page 2 s certificate After death.

Exami Physician/Medical þ Completed Be ၉ Certification: neral Director: / To the Hospital within 24 hours a To the Funeral C Medical

Month Day Year 1:04PM HOWARD LEE MULLIKIN MAY 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death TALBOT 702 WAYSIDE AVE. EASTON 8. Date of Birth (Month, Day, Year)

JULY 3, 1927 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 1**X** M 2□ F Months Days Hours Min. 80 MARYLAND 218-20-9077 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b County X Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 702 WAYSIDE AVE. 21601 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 QUALITY CONTROL OFFICER AGRICULTURE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be EDWARD MULLIKIN BERTHA UNKNOWN ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA CHEEZUM/DAUGHTER 611 WINDMILL ROAD, EASTON, MARYLAND 21601 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 5/4/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST. EASTON, MD 21601 MERCERON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final arrial turnel Years disease or condition resulting in death) Due to (or as a consequence of): Therescherotic heart disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury 4002 upertension that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Mnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1□ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 ☐ Nursing Home 5 🛣 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Dath 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

OND

505 DUTCHMANS LANE, EASTON, MD 21601

DILLYS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED I ALI M.D. 31. Date filed (Month, Day, Year)

MAY 0 5 2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:00 a M Merline Rosalin Mowatt ná 2008 May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Gaithersburg 18308 Swan Stream Drive Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🖼 F Yrs Jamaica, W.I. Director 218-13-4906 42 April 9, 1966 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐Yes 2 V No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 U.S.A. 18308 Swan Stream Drive Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify 2 Specify 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Healthcare Services Supervisor 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ena Naomi Blackford Ishmael Wiltshire 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18308 Swan Stream Drive, Gaithersburg, Maryland 20877 Errol H. Mowatt - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Parklawn Memorial Park 05/15/2008 Rockville, Maryland 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licens e 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Breat Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or many Due to (or as a consequence of) Examine The law requires that the death certificate be executed that initiated events resulting in death) Last and burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes or Attending Physician; director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 7 No Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t 28c. Injury at Work? Injury 1-Natural 5 ☐ Pending investigation death. 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospitai the P

State Registrar

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

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Tear) 2

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

DIJ 518

Elkridge.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mi

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Prive

Registrar

State

31. Date filed (Month, Day,

12

2008

12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
HCH 1500 Forest Glen Road Silver Spring, Maryland 20910 Barbara Supanich, RSM, MD

paruch, RSM MD

32. Registrar's Signature

D 0065 485

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Month 2008 Elizabeth Janice Morgan May 12, 10:15 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11812 Trenton Street Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours Min. 1 □ M 2 🗓 F 56 227-74-6135 Yrs Director 08/03/1951 Virginia Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits MD Allegany Cumberland 1 ☐ Yes 2 X No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11812 Trenton Street 21502 USA Funeral 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Deli Manager Grocery Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Mabel Octavia James 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11812 Trenton Street, Cumberland, MD Larry E. Absher / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Mem. Park :05/16/2008 Falls Church, VA 21. Si ma ure of Funeral Service Lice 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part Lener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Metasinho 5 4000 resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Únknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2∏No 1□ Yes 21 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Inpatient 1 Yes 2 No 2 ER/Outpatient ပ္ 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification:

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician has certificate or Attending Physician: After this

burial-tran the for use ed by the a signed by page director funeral ours after death.

neral Director: A
filled in by the fu To the Hospital o within 24 hours aft To the Funeral D

Funeral

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

28c. Injury at Work? (Month, Day Year) Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 29a. Certifier 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29c. License number

D0060478

29d. Date signed (Month, Day, Year)

May 13, 2008

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nes

State

Registrar

31. Date filed (Month, Day, Year) MAY 1 3 2008

Afaq Ahmad, M.D.,

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

904 Seton Drive, Cumberland, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician EUGENE** WILLARD MILLER 04 30 2008 2132 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-BRADDOCK CAMPUS CUMBERLAND ALLEGANY 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1 X M 2 □ F Director 213-24-5745 80 09/19/1927 Virginia West Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show ed⊩al Exaπiner must be notified at 1 ☐ Yes 2 No Allegany Director LaVale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filled within 72 hours after death with I Hygiene. 12400 Stoneybrook Lane 21502 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White It and Mental Hygiene.
It is marked other than "natural" 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11 Conductor Railroad ages 1 and 2 should be filed to the filed to the filed to the filed and Mental Hygis to the filed 27 is marked other to other traumatic event, the filed fil 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Melvin Martin Miller Helen Emma Everets 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Frances Miller / Wife 12400 Stoneybrook Lane, LaVale, Maryland 21502 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or ot
once. Pages 1払Burial 2 □Cremation 3 □Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hillcrest Mem. Park 05/05/2008 Cumberland, MD 21. Sign stun, of Funeral Service Liverse 22. Name and Address of Facility Adams Family Funeral Home, 21502 404 Decatur Street, Cumberland, MD 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequente of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner signed by the attending physician and be detached for use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 | Yes 2 No 3 | Probably 4 | Unknown certificate has been si rector, page 2 should l Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ≥ No 2 ER/Outpatient 3 DOA Inpatient | After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation To the Hospital or Attendla within 24 hours after death.

To the Funeral Director: All completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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State Registrar

31. Date filed (Month, Day, Year) MAY 0 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

IVE

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician NEWMAN 2008 061014 CARRIE E. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK NURSING HOME VINDOBONA MIDDLETOWN If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1□ M 20 F 90 MD. 214-36-3144 10-191 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Yes 2□No MO. FREDERICK MIDDLETOUN Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number OCD NATIONAL PIKI 21701 USA 2400 by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) FAMILY and Mental Hygiene.

Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC Home WNKI 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 and 2 should be GERTRUDE NEWMAN CHILL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ( ULCCL) 11310 INDIAN WELLS LANE permit. Pages 1 and 2:3 Department of Health an Important: If item 27 Is any Injury or other trau Bowie MA MARCIA OUGUS FOULLER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Femation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) SMITHSBURG CRGM. MAY 9, 2008 3 Removal from State SMINISBURG MD. 22. Name and Address of Facility CARY L. POLLINS FUN HUNG 21. Signature of Funeral Service Licensee ol FREDERICK MD 21701 110 WOST SOUTH ST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 15 18ars **Physician** Hunton eton /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner requires that the death certificate be executed burial-transf Due to (or as a consequence of): or Vital Records, P.O. Box 68760, attending physician use as the IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the aid be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After (Month, Day Year) Division Hospital or Attending 1 Natural 5 Pending investigation 1 □ Yes 2 □ No ours after death.
neral Director: At
filled in by the fu 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) ို 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

32. Registres Signature

2008 ▶

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03654 State of Maryland / Department of Health and Mental Hygiene Francis Michael Nance Certificate of Death Reg. No. 1- For State 3. Time of Death Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day May 13, 2008 Year 0933 hrs Physician/ Megir वा Examiner Francis Michael Nance c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Riverdale 6221 61st Place 9. Birthplace (State or Foreign 8. Date of Birth (MM/DD/YYYY) If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number Washington, DC **Funeral** Min. Months Days Hours 03/23/1960 48 213-84-3555 Yrs Director 1 XM 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 X No Bowie Prince George's MD Hygiene. d other than "natural", or items 23a or 28a-f shov , the Medical Ex iminer must be notified at once. 10g. Citizen of What Country? Directo 10f. Zip Code 10e. Street and Number 20715 12312 Shelter Lane Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No Yes 1 Yes 2 X No specify: SpecifyWhite If Yes, Give Year Divorced 3 Widowed within 72 hours after 16b. Kind of Business/Industry ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 h.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n injury or other traumatic event, the Medical E. Elementary/Secondary (0-12) Irrigation Owner 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joan T. McGivern James B. Nance Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Bowie, MD 12312 Shelter Lane Joanne T. Lafon / Sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place)
Metropolitan
Crematory Removal from State Burial 2 X Cremation 3 5/30/2008 Alexandria, VA Donation 5 Other Specify. 22. Name and Address of Facility Beall Funeral Home 21 Stenature of Funeral Service Licenses 20715 MD 6512 NW Crain Hwy. Bowie, 26a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. ledical Cardiac arrhythmia Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Myocardial scar Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and APPINGE ne a-b, 27, perME, g879 5/29/.08 TT X UNPENDED 23d. Date of delivery

Approximate Interval Between Onset and

Death

Year

2 No

24b. Were autopsy findings available

29d. Date signed (Month, Day, Year)

May 14, 2008

prior to completion of cause of death?

Month

The law requires that the death certificate be executed Physician/Medical attending physician a for use as the burial -68760, 23c. If yes, outcome of pregnancy IF FEMALE: 3 Ectopic pregnancy 2 Fetal death 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? n signed by the a d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 V Unknown Ö ģ Completed 24a, Was an Records, page 2 should autopsy performed' certificate has Yes 2 V No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director. Division of Vital Be Other: Nursing Home 5 Residence 6 Other: Scene Hospital: DOA ER/Outpatient 3 Inpatient 2 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Yes 2 No 1 X Natural 5 Pending 28f. Location (Street and Number or Rural Route Number, City Accident Investigation 2 28e. Place of Injury - At home, farm, street, factory, office building, etc.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

MAY 2 1 2008 Registrar OCME **ORIGINAL** 

Could not be

determined

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

3 Suicide

29a. Certifier 1

Homicide

29b. Signature and title of certifier

Ana Rubio MD.

90

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death **Physician** APRIL 30 2008 0900 anci /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT 315 DUTCHMANS LANE EASTON 8. Date of Birth (Month, Day, Year)
AUG 28,1946 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 XM 2 ☐ F FLORIDA Director 579-58-7174 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show deal Examiner must be notified at EASTON 1XYes 2 No Director MD TALBOT 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 315 DUTCHMANS LANE 21601 USA Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) LEGAL SYSTEM LAWYER 12 12 should be filed w h and Mental Hygie 7 is marked other tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOHN T. O'CONNOR MERVYNE HINSKE 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any injury or other tratonce. PAMELA A. O'CONNOR/WIFE 315 DUTCHMANS LANE, EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State HOLY GHOST CHURCH CEM. 5/10/2008 NEW BURGE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 LSTROWNE C.F.SP. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) seare Onset and Dea phar **Physician** /Medical Due to (or as a conseque ce of Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner requires that the death certificate be executed and burial-trar Box 68760 attending physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4□Pregnant at time of death 5 Other (specify) Records, P.O. the 9 Unknown þ signed l death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has be irector, page 2 s autopsy 1∐ Yes 2d No Division or Vital director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner eath 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Medical Certification: Hospital or Attending 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 💟 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier IC NR person who completed cause of death (Item 23a) (Type, Print) 30. Name and a dress of man 32. Registrar's Signature 31. Date filed (Month, Day, Year 0 5 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

|                                |  |                     | - State Amend Item<br>Registrar  | State of Ma<br>17 per inf   | aryland / D                                  | epartment of the control of the cont | fealth and M<br><i>Death</i> | lental Hygid<br>Reg                              | ene<br>, <sub>No.</sub> 2008                | 3 - 17089   |
|--------------------------------|--|---------------------|--|---|--|--|------------------------------|--|---|---|
|                                | Physicia   | · ·                 | 1. Decedent's Name (First, Middle, La  | st)   |  |  |                              | 2. Date of Death<br>Month                        | Day Year                                    | 3. Time of Death  |
| ~                              | /Medic   |                     | Amir Hossein   |   | am   |  |                              | May 6, 2   | 800   | 11:15 a <sup>M</sup>  |
| 1/2                            | Examin   | er                  | 4a. Facility Name (If not institution, give  |   |  |  | r Location of Death          |  | 4c. County of Dea                           |   |
|                                | Europel  |                     | Suburban Hospi  5. Social Security Number 6. 8   |   | e (In yrs. last birth                        | Betheso  |                              | 8. Date of Birth<br>(Month, Day,                 |   | thplace (State or Foreign   |
|                                | Funeral<br>Director  |                     | 578-04-0909  | MM 2□F 88   | e (In yrs. last birth<br>Y                   | rs. Months Days  | Hours Min.                   | Oct 11,  | 1919 Ira                                    | n.  |
|                                | and  |                     | Usual Residence of Decedent  10a. State 10b. County                                    |   | 10c. City, Town                              | or Location  |                              |  |   | 10d. Inside City Limits   |
|                                | Maryl<br>f sho   | tor                 | MD Montgo  | mery  | Bethes                                       | da   |                              |  |   | 1 □ Yes 21∐ No  |
|                                | h the<br>or 28a  | irec                | 10e. Street and Number   |   |  | 10f. Zip Code  |                              | 100  | g. Citizen of What Co                       | ountry?   |
|                                | 23a c  | ral                 | 5225 Pooks Hil   | 1 Road #  | 411 N  | 20814  |                              |  | ran   |   |
| 036                            | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced            | 12. Was Decedent I<br>Armed Forces?<br>1 ∐Yes 2 ☑<br>If Yes, Give<br>Year or Dates: |  | 13. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 ☑ No   |                              | ecify Yes or No-<br>Rican, etc.)                 | 14. Race - Ame<br>Black, Whit<br>Specify: W | te, etc.  |
| 5-0                            | 72 ho<br>'natur  | eted                | 15. Decedent's E<br>(Specify only highest gro  | ducation<br>ade completed)  | 1 (  | Decedent's Usual Occup<br>Give kind of work done   | during most of works         |  | 6b. Kind of Business                        | /Industry   |
| 121                            | within<br>ene.<br><b>than</b>  | Completed           | Elementary/Secondary (0-12)  | College (1-4or 5  | +)   | life. DO NOT use retire  | -/                           |  | Health                                      |   |
| 0                              | filed<br>Hygi<br>other<br>ent, I   | Be C                | 17. Father's Name (First, Middle, Last   | ) .7.   |  |  |                              | e (First, Middle, Ma                             | niden Surname)                              |   |
| /lan                           | Menta<br>Menta<br>Irked<br>Itic ev   | 일                   | <del>Hossein Partoa</del>  | zam Ali   | Partoaza                                     | am<br>   | Massou                       | meh Maj  | di  |   |
| , Mar                          | and 2 sho<br>salth and 1<br>27 is m8<br>er traums  |                     | 19a. Informant's Name/Relationship<br>Zahra Partoaza                                   |   | ter   61                                     | Mailing Address (Street 56 Valer)  | and Number or Run<br>an Lane |  |   |   |
| Baltimore, Maryland 21215-0036 | Pages 1<br>ment of He<br>ant: If Iten<br>ury or oth  |                     | 20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci  |   | 20b. Place of I<br>cemetery<br>Nation<br>Par |  | <sup>ce)</sup> 1 5/10        | /08 F <sub>6</sub>                               | oc. Location - City or                      | rch, VA   |
| Balt                           | permit. Depart Import any Inj  | 1                   | 21. Signature of Funeral Service Lice Diana L.   | Down-   | 21   | 22. Name and Addre   |                              |  |   | Home 7482<br>2  |
| П                              |  |                     | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only           | one cause on each lir   | 1 <del>0</del> .                             |  |                              | or respiratory arres                             | st,   | Approximate<br>Interval Between<br>Onset and Death                              |
| -                              | Physician<br>/Medical  |                     | Immediate Cause (Final disease or condition resulting in death)                        | <b>a</b>  |  | ory Failu  | ıre                          |  |   | Short and Boam  |
| of the                         | Examiner   |                     |  |   | a consequence of<br>ntersti                  | ):<br>tial Puln  | nonary F.                    | ibrosis  |   |   |
|                                | p ±  | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying     | b<br>Due to (or as  | a consequence of                             | :):  |                              |  |   |   |
|                                | ecute<br>and<br>transi   | Examiner            | Cause (Disease or Injury that initiated events resulting in death) Last                | C   | a consequence of                             |  |                              |  |   |   |
| 68760,                         | ificate be executed<br>g physician and<br>is the burial-transit  | alE                 |  | Due to (or as   | a consequence of                             | <i>)</i> .   |                              |  |   |   |
| 687                            |  | edical              |  | d   |  |  |                              |  |   |   |
| .O. Box                        | that the death certificated by the attending posterior of the attending posterior and the transfer as  | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome<br>1  Live birth<br>4  Pregnant a<br>9  Unknown                | 2 Fetal death                                | 3 ☐ Ectopic pregnan<br>5 ☐ Other (specify)   | су                           |  | 23d. Date of de<br>Month                    | elivery<br>Day Year   |
| s, P.                          | s that<br>ined b   | by Ph               | Part II. Other significant conditions  | contributing to death b   | ut not resulting in                          | the underlying cause giv   | ven in Part I.               | 23e. Did toba                                    | cco use contribute                          | to the cause of death?  |
| ğ                              | w requires<br>been sign<br>should be   |                     |  |   |  |  |                              | 1 ☐ Yes  | 2 € No 3 ☐ F                                | Probably 4 🗆 Unknown  |
| Division of Vital Record       | The lar  | Completed           |  |   |  |  |                              | 24a. Was an<br>autopsy<br>performe<br>1 ☐ Yes 21 | prior to death?                             | autopsy findings available completion of cause of s 2 \( \subseteq \text{No} \) |
| Vita                           | hysiclan: The<br>nis certificate<br>I director, pag  | Be (                | 25. Was case referred to medical examiner?   | Hemital   |  | lou  |                              | h (Check only one)                               |   |   |
| of                             | Physic ruthis or ral dire  | 2                   | 1 ☐ Yes 2 ☐No<br>27. Manner of Death   | Hospital: 1   Inpatie   |  |  |                              | ome 5 Residen                                    | ce 6 Other (Sp                              | ecify)  |
| on                             | Attending Physician: If death. ector: After this certification by the funeral director, it   | tion                | 1 Natural 5 Pending 2 Accident investigatio  | (Month, Da  | y, Year) In                                  | ury Wo   | rk?<br>]Yes 2 □No            | 28d. Describe flow                               | rinjury occurred                            |   |
| Divis                          | i Diffic   | Certification:      | 3 ☐ Suicide 6 ☐ Could not be determined  |   |  | m, street, factory, office   |                              | 28f. Location (Stre<br>City or Town,             | eet and Number or F<br>State)               | Rural Route Number,   |
|                                | the Hospital<br>thin 24 hours a<br>the Funeral I<br>mpletely filled  | Medical C           |  |   | f examination and                            | death occurred at the t<br>/or investigation, in my  |                              |  |   |   |
| _                              | within the state of the state o | ž                   | 29b. Signature and title of certifler  |   | ^  | 29c. Licen   |                              |  | d. Date signed (Mor                         |   |
|                                | (5)  |                     | 100/6  | ce  | Su   |  | 55 MD                        |  | ay 8, 20                                    |   |
|                                | Je.  |                     | 30. Name and address of person who Carlos Picons                                       |   |  | ype, Print) ngin Ave.  | , \$930,                     | Chevy C  | hase, MI                                    | 20815   |
|                                | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year) MAY 1 3 2008   | 32. Registr   | ar's Signature                               | ,  |                              |  |   |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ам Barbara Frances Pritchard 5/8/2008 7:50 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Westminster Dove House Hospice Carrol1 7 Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2**K** F 67 2/17/1941 Director Washington, D.C. 213-38-3865 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 No Director MD Prince George's New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20784 U.S.A. 7917 Legation Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or iter any Injury or other traumatic event. the Meclical Fyaminar 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant County Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Andrew Stephen Rosemary Sarah Theresa Dunn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Schneider, Daughter 1618 Bowersox Rd., New Windsor, MD 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/12/2008 Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 25a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Vaginal Cancer year /Medical Due to (or as a consequence of): Examiner Anemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1☐Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 X No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate 2 X No 1∐ Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other:  $_{4\,\square\,\,\text{Nursing Home}}$  5  $\square\,\,\text{Residence}$  6  $\square\,\,\text{Other}$  (Specify)  $\square\,\,\text{Hospice}$ 1 ☐ Yes 2 No 2 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 X Natural Injury 5 Pending death. investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendential 24 hours after death To the Funeral Director: completely filled in by the

> Name and address of person who completed cause of death (Item 23a) (Type, Print) HO Carta Steel Wastminster, MD 2115 State 2008 Registrar ORIGINIAL

and manner stated

1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

29a. Certifier

29b. Signature and title of certifier

Medical

|                   |  |                  | For State   | State of Maryla   |                            |   |                   |                         | Hygier                      | 10                      |                                     |               |
|-------------------|--|------------------|---|---|----------------------------|---|-------------------|-------------------------|-----------------------------|-------------------------|-------------------------------------|---------------|
|                   |  |                  | Registrar  1. Decedent's Name (First, Middle, Las                                     |   | Ce                         | rtificate of                                    | Death             | 2. Date                 | Reg. N                      | 4o.2 0 0                | 3 Tim                               | ie of Death   |
| P                 | Physici  |                  |   | ,<br>ane Pearsall   |                            |   |                   | Mont                    | 1 E                         | Day Yea                 | ar .                                |               |
| g.                | /Medic   |                  | 4a. Facility Name (If not institution, give   |   |                            | 4b. City, Town, o                               | or Location       |                         |                             | 4c. County of D         |                                     | <u> </u>      |
|                   | ş  |                  | Memorial Ho   | spital Eas  | note                       | Eas   |                   |                         |                             | Talbo                   |                                     |               |
|                   | Funeral  |                  | 5. Social Security Number 6. Se   | TM 2₽F  | rs. last birthday)<br>Yrs. | If Under 1 Year<br>Months Days                  | If Under<br>Hours | Min. (Mont              | h, Day, Yea                 |                         |                                     |               |
| e.                | Director   |                  | 438-68-9248 Usual Residence of Decedent   | 0   | 7 Yrs.                     |   |                   | Septer                  | nber 5                      | , 1940                  | Maryland                            | <u>a</u>      |
|                   | ryland<br>how  |                  | 10a. State 10b. County  | 10c.  | City, Town or Lo           | ocation   |                   |                         |                             |                         |                                     | e City Limits |
|                   | ne Ma<br>8a-f s  | cto              | Maryland Caroli   | ne G  | oldsbor                    | 7   |                   |                         |                             |                         |                                     | Yes 2 No      |
|                   | with the   | Dire             | 10e. Street and Number  |   |                            | 10f. Zip Code                                   |                   |                         |                             | Citizen of What         |                                     | Amaniaa       |
|                   | leath<br>ns 23<br>must   | Funeral Director | 15501 Union Road  | 12. Was Decedent Ever in  | U.S. 13.                   | Was Decedent of                                 | Hispanic O        | rigin? (Specify Yes     |                             |                         | merican Indian                      |               |
| 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  | by Fur           | 1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced                                  | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:                                    |                            | If Yes, specify Cub                             |                   |                         | ;.)                         |                         | Vhite, etc.<br>Caucasia             | an            |
| 2-0               | 72 ho<br>'natur<br>dical   | Completed by     | 15. Decedent's Ed<br>(Specify only highest grad                                       |   | i (Give                    | edent's Usual Occu<br>kind of work done         | during mo         | st of working           | 16b.                        | . Kind of Busine        | ess/Industry                        |               |
| 121               | within<br>ene.<br>than '   | lg m             | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                            | DO NOT use retire<br>Caregiver                  | a)                |                         |                             | disable                 | ed<br>Persons                       |               |
|                   | filed<br>Hygic<br>Sther<br>ent, th   | Be Co            | 17. Father's Name (First, Middle, Last)   |   |                            | diegivei  | 18. Moth          | ner's Name (First, M    | iddle, Maid                 |                         | CIBOIIS                             |               |
| Maryland          | Jid be<br>Jental<br>rked (<br>tic ev   | To B             | William Steve   | ens Orme  |                            |   | M                 | lartha Bla              | ckist                       | one                     |                                     | _             |
| lary              | 2 shou<br>and N<br>Is ma<br>auma   |                  | 19a. Informant's Name/Relationship (7   |   |                            | 3   | and Numl          | ber or Rural Route I    | lumber, Cit                 | ty or Town, Stat        | te, Zip Code)                       |               |
|                   | l and<br>lealth<br>im 27<br>ther tr  | 1                | Joseph Pearsall   | Husband   |                            |   |                   | Goldsbor                |                             | ryland  Location - City | 21636                               |               |
| 200               | nt of h  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3                                    | Removal from State  |                            | osition (Name of<br>ematory or other pla        |                   |                         |                             |                         |                                     | 5             |
| Baltimore,        | nit. Partme<br>ortani<br>Injury  |                  | 4 □ Donation 5 □ Other (Specify 21. Smature Funeral Service/Licen                     | -Am   |                            | Cremato:<br>2. Name and Addre                   | - 1               | 5/16/2008               |                             | over, De                | Haware                              |               |
| B                 | Departiment Departiment Important Information and Irrespondent Irrespo | 0.8              | 1 cember  | 1 nous  | - 1 N                      | loore Fun<br>2 South                            | eral<br>Secon     | Home, P.A<br>d Street,  | Dent                        | on, Mar                 | yland :                             | 21629         |
|                   |  |                  | 23a. Part1. Enter the disease or composhock, or heart failure. List only              | plications that caused the de   | eath. Do not er            | ter the mode of dy                              | ing, such a       | s cardiac or respirat   | ory arrest,                 | •                       | Approxi<br>Interval                 | Between       |
|                   | Physician  |                  | Immediate Cause (Final disease or condition resulting in death)                       | a. Metast   | atic                       | maliqu  | rant              | direar                  | e_                          |                         |                                     | and Death     |
|                   | /Medical<br>Examiner   |                  | resulting an death)   | Due to (or as a cons  | equence of):               |   |                   |                         |                             |                         |                                     |               |
|                   |  | ē                | Sequentially list conditions,   | b. Due to or as a cons  | sequence of                |   |                   |                         |                             |                         |                                     |               |
|                   | cuted<br>od<br>ransit  | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events                | С   |                            |   |                   |                         |                             |                         |                                     |               |
| 9                 | icate be executed<br>physician and<br>the burial-transit   | EX               | resulting in death) Last  | Due to (or as a cons  | sequence of):              |   |                   |                         |                             |                         |                                     |               |
| 68760,            |  | dical            |   | d   |                            |   |                   |                         |                             |                         |                                     |               |
| Box               | law requires that the death certific<br>as been signed by the attending p<br>2 should be detached for use as   | by Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 23c. If yes, outcome pf pre<br>1 ☐ Live birth 2 ☐ F<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | etal death 3               | □Ectopic pregnanc<br>□ Other <i>(specify)</i> _ | ;y                |                         |                             | 23d. Date of<br>Month   | f delivery<br>Day                   | Year          |
| , P.O.            | that the   | / Ph             | Part II. Other significant conditions of  | ontributing to death but not  | resulting in the           | underlying cause gi                             | ven in Part       | I. 23e.                 | Did tobacc                  | co use contribut        | te to the cause                     | of death?     |
| rds               | quires<br>n sign<br>uld be   |                  |   |   |                            |   |                   |                         | 1 ☐ Yes                     | 2□ No 3                 | <b>≰</b> Probably 4                 | ‡ ∐Unknown    |
| Records,          | law re<br>as bee<br>2 sho  | Completed        |   |   |                            |   |                   | 24a.                    | Was an autopsy              | 24b. Wer                | e autopsy findir<br>r to completion | ngs available |
| <u>~</u>          | The ate has page   | Som              |   |   |                            |   |                   | 10                      | pertormed                   | !? deat                 | th?                                 |               |
| Vita              | Physician:<br>r this certificaral director, I  | Be               | 25. Was case referred to medical examiner?  | Hospital:   |                            | Ot  | 26. Plac          | ce of Death (Check      | only one)                   |                         |                                     |               |
| ō                 | ding Physician: The lavh. After this certificate has funeral director, page 2.   | <u>-</u>         | 1 ☐ Yes 2 No 27. Manner of Death  | 28a. Date of Injury   | 28b. Time                  | III 3 DOA                                       | 4 L N             | lursing Home 5 28d. Des |                             | e 6 Other (S            | Specify)                            |               |
| ion               | Attending<br>r death.<br>ector: After<br>by the fune   | ation            | 1 Natural 5 Pending<br>2 Accident investigation                                       | (Month, Day Year  | ) Injury                   |   | orƙ?<br>]Yes 2[   | ]No                     |                             |                         |                                     |               |
| Division or Vital | al or Atte<br>s after des<br>Il Directo  | Certification:   | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of injury - A building, etc. (Spe  | t home, farm, si           | treet, factory, office                          |                   |                         | tion (Street<br>or Town, St | t and Number o<br>tate) | r Rural Route i                     | Number,       |
|                   | To the Hospital or Attendia within 24 hours after death.  To the Funeral Director: A completely filled in by the fu  | Medical C        |   | ysician: To the best of my<br>niner: On the basis of exam<br>and manner stated.               |                            |   |                   |                         |                             |                         |                                     | ıse(s)        |
|                   | To the vithing to the complex to the | ž                | 29b. Signature and title of certifier   |   |                            |   | se number         |                         |                             | Date signed (M          |                                     |               |
|                   |  | Į,               | > KRainer   | ~ MD  |                            | -   | 066               | 441                     | Mo                          | 7 13                    | 200                                 | 0             |
|                   |  | 1                | 30. Name and address of person who kolin Rame kn                                      | completed cause of death (I   | tem 23a) (Type             | gton Sin  | ect               | 441<br>Easton           | WD                          | 216                     | 01                                  |               |
|                   | Sta<br>Regist  |                  | 31. Date filed (Month, Day, Year)   | 2195<br>Registrar's Si  | griature                   |   |                   |                         |                             |                         |                                     |               |

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death Month May 8, **Physician** James Donald Peoples 2008 10:00 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8. Date of Birth (Month, Day, Year) 28. 1934 Montgomery

9. Birthplace (State or Foreign Country) Shady Grove Adventist Hospital Rockville If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** 1₽M 2□F Hours Days Months 267-44-0127 73 Yrs. Tennessee Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo Maryland Montgomery Poolesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20300 Whites Ferry Road 20837 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Y⊆ Yes 2 No If Yes, Give 1 Mever Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Specify. ģ If Yes, Give Year or Dates: Specify: 1954-56 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Model Maker Federal Government 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) Be James Harold Peoples Willie Mae Mink 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Hunter/Sister 12505 Summerwood Drive, Silver Spring, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State May 13, Fort Lincoln Cemetery Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fu eral Signature of Fu 2008 21. Si 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. 2 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Lymphoma Physician 7 years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Decade of Injury) that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) 1 Tyes 2 TNo 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? res 2 ☐ No certificate 2 □ No 1∐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Thpatient 1 Tyes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To this funeral After

Division or Vital Records, P.O. Box 68760. or Attending Physician:

ours after death.

neral Director: #
filled in by the for To the Hospital o within 24 hours aft To the Funeral Di

10+1

| ation         | 1 Natural                             | 5 ☐ Pending investigation  | (Month, Day Year)                                      | Injury                      | Work?<br>1 ☐ Yes 2 ☐ No      | 200. Describe              | e now injury occurred  |  |
|---------------|---------------------------------------|----------------------------|--|-----------------------------|------------------------------|----------------------------|--|--|
| Certification | 3 ☐ Suicide<br>4 ☐ Hornicide          | 6 Could not be determined  | 28e. Place of injury - At h<br>building, etc. (Special | ome, farm, street, factory) | ory, office                  | 28f. Location<br>City or T | (Street and Number or Rural Route Number, own, State)                        |  |
| dical         | 29a. Certifier<br>(Check only<br>one) |                            |  |                             |                              |                            | ne cause(s) and manner as stated. e, date and place, and due to the cause(s) |  |
| Me            | 29b. Signature and                    | title of certifier  Leph M | . Hazzerty   | -mD 2                       | 9c. License number<br>D32407 |                            | 29d. Date signed (Month, Day, Year)  May 8, 2008                             |  |

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9707 Medical Center Drive, Rockville, MD 20850

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Physician Joyce Lynn Printy May 2008 М 10 1150 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WMHS-Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/26/1956 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 X F Yrs. 51 Maryland 213-76-4317 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 Ñ No Director MD Allegany Cresaptown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14521 Winchester Road, SW 21502 USA Funeral within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. 3 ☐ Widowed 4 ☑ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wir.
Department of Health and Mental Hygien.
Important: If item 27 is marked other the any Injury or other traumatic event. the 12 Housekeeping Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Frederick Logsdon Doris Jean ပ Robinson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shawn R. Printy / Son 12525 Diamond Lane, Corriganville, MD 21524 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Cook's Mill Cemetery 05/13/2008 Hyndman, PA 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service bicen 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Brainstem Compression /Medical Due to (or as a consequence of) Examiner Brain Metastases Sequentially list conditions Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine death certificate be executed Lung Cancer burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending IF FEMALE use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🏋 No 3 Ectopic pregnancy ρģ Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Ö the 9☐Unknown 9 Unknown by ٦. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has page 2 autopsy performe death? 1 ☐ Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? or Attending 1X Natural Injury 5 Pending thin 24 hours after co-1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🛣 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier

State Registrar

MAY 1 3 2008

30. Name and add

31. Date filed (Month, Day, Year)



ess of person who completed cause of death (Item 23a) (Type, Print)

MAS

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D18216

29d. Date signed (Month, Day, Year)

May 12, 2008

21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🙎 🕦 🖯 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day **Physician** 06:45 AM M April 30, 2008 Thomas William Preston /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Frostburg Village Nursing Care Center Frostburg Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 1**X**M 2□ F 216-18-1379 83 Maryland March 31, 1925 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10a. State 28a-f show aţ 1 Yes 2 □ No Director Frostburg Maryland Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20 Howard Street ō other traumatic event, the Medical Examiner must be U.S.A. or items 23a 21532within 72 hours after death Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
10 Yes 2 No WWT
If Mes, Give Year or Dates: Korean 168 I 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: þ 3 Widowed 4 □ Divorced White "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clarence William Preston Anna Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Gail McKenzie daughter Maryland 78 Armstrong Street Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State National Supposition 

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Natio May 03, 2008 Maryland Frostburg Memorial Park Frostburg 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 ohn 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final er ebro VASCULAR Physician WEEKS disease or condition resulting in death) /Medical to (or as a consequence of): PER TENSION Examiner Esquentially liet on differe, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and it be detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, certificate be Physician/Medical Arm 30,3008 IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death in the past 12 months? Month Day Year 5 Other (specify) 1 Ves 2 No 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ARTERY Completed ATERIAL FIBER 11 PHION 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 25 No has Disbetes 1□ Yes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 2 completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? al or Attending Platter death.

I Director: After the Certification: J Few 5 ☐ Pending investigation PATIENT DOWN 1 Natural 1 Yes 2 No a FIPRIL 5 2008 2 Accident 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide GREENE ST FROSTBURG To the Hospital within 24 hours a Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

nds State Registrar

SANdhiR 31. Date filed (Month, Day, Year) MAY 0 2 2008



30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 16,2008 **Physician** 1835 May Helen M. Rose /Medical 4c. County of Death 4a, Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Annapolis
| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Arundel Anne Anne Arundel Medical Center Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** 1 □ M 2 □ F 366-28-4260 April20,1926 Michigan Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 🏋 ☐ No Director Anne Arundel Maryland Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with U.S.A. 21122 8002 Corkberry Lane #209 Funeral within 72 hours after death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No If Yes, Give Specify: White ģ 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Homemaker Own Hôme 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Balamucki Pages 1 and 2 should 2 Andrew Pabis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21122 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trauonce. 8002 Corkberry Lane #209, Pasadena, Maryland Gayle Wenta / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State New CalvaryCatholic 5-22-08 Flint, Michigan 4 ☐ Donation 5 ☐ Other (Specify) Cometery Name and Address of Facility Marzullo Funeral Chapel, P. A 21. Signature of Funeral Service Licensee michael P. 9 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MAN ous **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sunsequence of) Examine requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ZNo Pregnant at time of death 5 ☐ Other (specify) P.O. signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐ Yes 2 ☐ No 1 □Yes Physician; 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examinec? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) No DS 1 🗀 Yes Inpatient 2 ER/Outpatient 3 DOA After this Certification: To To the Hospital or Attending Plewithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1/📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 608

Registrar
DHMH 17 Rev 1/2001

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State

undel Medical Center Annapolis, Md. 21146

cause of death (Item 23a) (Type, Print)

Registrar's Signature

ddress of person who complete

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:55 P M 5/5/2008 Ruth Lucille Rynarzewski /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Country Home Assisted Living Anne Arundel Harwood Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Annapolis, MD 92 10/29/1915 **Director** 216-30-8224 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 1 ☐ Yes 2 ☑ No Director Anne Arundel Friendship 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number r than "natural" or items 23a or the Medical Examiner must be 20758 United States 460 Avon Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: White þ 3 to Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Housewife Own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bonnie Lucille Dufour Carl Alan Wagner 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 Is any injury or other trau once. 460 Avon Court, Friendship, MD in-law Carol Ann Rynarzewski 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/9/08 4 Donation 5 Other (Specify) Fort Lincoln Cemetery Brentwood, Maryland 21. Signature of Fur eral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, PA Hyattsville, MD 20781 knot U 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEMENTIA Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Year Month Day in the past 12 months? 5 Other (specify) signed by the a I□Yes 2□No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 X No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Assisted Living 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury 28c. Injury at Work? Injury (Month, Day Year) 5 □ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

841 State

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DHMH 17 Rev 1/2001

the

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31. Date filed (Month, Day, Year)
MAY 1 3 2008 Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

40370

| Ame             | nded #s  | 2.5<br>n1s        | 28b<br>, 27; nls, Plea<br>s, 05/02/08,   | se Type or Prin   | t in Black In                           | delible lnk   | . Ensure                               | All Copies                                | Are Le              | gible.                |  |
|-----------------|--|-------------------|--|---|---|---|--|---|---------------------|-----------------------|--|
| A11             | egany C  | ю.                | For State Registrar  | State of Ma   | in y land / Dope                        | artment of H<br>rtificate of                                | rountil alla                           | Wiorital Tijg                             | giene<br>leg. No. 2 | 008                   | 17097  |
|                 | Physici  | an                | 1. Decedent's Name (First, Middle  | , Last)   |   |   |  | Date of Dea     Month                     | ith<br>Day          | Year                  | 3. Time of Death                                   |
|                 | /Medic   | _                 |  | ROBINSON  |   |   |  | 04  | 27                  | 2008                  | 1805 p M   |
|                 | Examir   | ner               | 4a. Facility Name (If not institution  | , give street and number)                                 |   |   | r Location of Dea                      | th  |                     | unty of Death         |  |
|                 |  |                   | WMHS MEMORIAL 5. Social Security Number  |   | (In yrs. last birthday)                 | CUMBERI<br>If Under 1 Year                                  |  | s. 8. Date of Birth                       | `                   | LEGANY<br>9. Birtho   | place (State or Foreign                            |
| - 10            | Funeral Director   |                   |  | 1 □ M 2 🟋 F   | 99 Yrs.                                 | Months Days   | Hours Min                              |   | 1909                | Cour                  | VIRGINIA   |
|                 | Ψ./  |                   | 236-64-7958<br>Usual Residence of Decedent   |   |   |   |  |   |                     |                       |  |
|                 | anylar<br>show<br>d at   | _                 | 10a. State 10b. County   | דגרי  | 10c. City, Town or Lo                   |   |  |   |                     | 1                     | 10d. Inside City Limits 1 ☐ Yes 2X No              |
|                 | he Ma-f  | Director          | WV MINI  | KAL   | KIDSEDE.                                |   |  |   | 10= 0:1:            | of What Cour          |  |
|                 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther than "natural", or items 23a or 28a-f show<br>ant, the Medical Examiner must be notified at   |                   | 10e. Street and Number  27 POTOMAC STE   | )<br>FFT  |   | 10f. Zip Code 2675  | 3                                      |   | -                   | S.A.                  | nuy?   |
|                 | leath<br>ns 23<br>must   | Funeral           | 11. Marital Status   | 12 Was Decedent F   | Ever in U.S. 13.                        |   |  | Specify Yes or No-                        |                     | Race - Americ         | can Indian,  |
| "               | r iten   | 臣                 | 1 Never Married 2 Marr   | Armed Forces?   | ol                                      |   |  | Specify Yes or No-<br>erto Rican, etc.)   | 1                   | Black, White,         |  |
| 03              | ours a<br>raf", o<br>Exan  | by                | 3 XWidowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:                            |   | 1 □ Yes 2 🛣 No  | Specify:                               |   | Sp                  | ecify: WHI'           | TE   |
| 5               | 72 hd<br>'natu<br>dical  | etec              | 15. Deceden<br>(Specify only higher  | t's Education<br>st grade completed)                      |   | dent's Usual Occu<br>kind of work done<br>DO NOT use retire |  | orking <sub>I</sub>                       | 16b. Kind           | of Business/In        | dustry   |
| 21215-0036      | vithin<br>nne.<br><b>han</b> '   | Completed         | Elementary/Secondary (0-12)  | College (1-4or 5  | +)                                      | DO NOT use retire<br>MEMAKER                                | d) -                                   |   | НО                  | ME                    |  |
|                 | al Hygie<br>other t  |                   | 17. Father's Name (First, Middle,  | Last)   | 110                                     |   | 18. Mother's Na                        | ame (First, Middle,                       | Maiden Sui          | rname)                |  |
| Maryland        | 8 m e  | To Be             | HENRY CLAY TAI   |   |   |   | ICY IS                                 |   |                     | ,                     |  |
| Z.              | ss 1 and 2 should b<br>of Health and Ments<br>item 27 is marked<br>r other traumatic e   | ۳                 | 19a. Informant's Name/Relations  | hip (Type. Print)   | 19b. Maili                              | ng Address (Street  | l<br>and Number or F                   | Rural Route Numbe                         | er, City or To      | own, State, Zij       | o Code)  |
|                 | nd 2<br>alth a<br>27 is<br>er tra  |                   | AVENOL BUCY /  | DAUGHTER  | P.                                      | O. BOX 68   | 33, RIDG                               | ELEY, WV                                  | 2675                | 3                     |  |
| Je,             | es 1 a of He of He rothe   |                   | 20a. Method of Disposition   | 0 □Demonal from Chate                                     | 20b. Place of Dispo<br>cemetery, cre    | matory or other pla   | ce)                                    | Date                                      |                     | ion - City or To      |  |
| <u><u>Ĕ</u></u> | Pages<br>nent of It<br>ant: If Ite   |                   | 1XI Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (S                              |   | HILLCREST                               | MEML. P   | ARK 04/                                | 30/2008                                   | CUM                 | BERLAN                | D, MD  |
| Baltimore,      | permit. Pages 1 Department of H Important: If Ite any Injury or ot   |                   | 21. Signature of Funeral Service   | Licensee  | 2                                       | 2. Name and Addre   | ess of Facility                        | I HOME. F                                 | P.A.                |                       |  |
|                 | 2018   | Ш                 | Gronory Y  | 1. Lyckell  | ch                                      |   |  | L HOME, E<br>ET, CUMBE                    |                     | ), MD                 | 21502  |
|                 |  |                   | 23a. Part1. Enter the disease, or shock, or heart failure. List                    | complications that caused only one cause on each lin      | the death. Do not en<br>le.             | ter the mode of dy  | ng, such as cardi                      | ac or respiratory ar                      | rest,               |                       | Approximate<br>Interval Between<br>Onset and Death |
|                 | Physician  |                   | Immediate Cause (Final disease or condition resulting in death)                    | _a Sub  | DURAL                                   | HEM   | ATOMA                                  | 7   |                     | F                     | 5 Days   |
|                 | /Medical<br>Examiner   |                   | resulting in death)  | Due to (or as a   | a consequence of):                      |   |  |   |                     |                       | 9  |
|                 |  | Į.                | Sequentially list conditions, if any, leading to immediate gause. Enter Underlying | b   | a consequence of):                      |   |  |   |                     |                       |  |
|                 | xecuted<br>and<br>Il-transit   | xamine            | Cause (Disease or injury   |   |   |   |  |   |                     | 1                     |  |
| oʻ.             |  | Exa               | that initiated events<br>resulting in death) Last                                  | Due to (or as   | a consequence of):                      |   |  |   | 1 17                |                       |  |
| 68760,          | ficate be ex<br>physician<br>s the burial  |                   |  | d   |   |   |  |   | 0/                  | han                   |  |
| 89              | rtifica<br>ng ph<br>as th  | Physician/Medical | IE ECNALE.   |   |   |   |  |   |                     | 100                   | MAY 1,2008   |
| Box             | eath certif<br>attending<br>for use a  | an/l              | 23b. Was decedent pregnant   | 23c. If yes, outcome                                      |   | Ectopic pregnanc  | ;y                                     |   | 23d                 | I. Date of deliv      | ,  |
| . E             | e deatl<br>he atte<br>ied for  | sici              | in the past 12 months?<br>1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown                            | 4□Pregnant at<br>9□Unknown                                |   | Other (specify)   |  |   |                     | Month                 | Day Year   |
| P.O.            | that the de<br>ed by the a<br>detached i   | Phy               | Part II. Other significant condition   | one contributing to death bu                              | it not reculting in the i               | inderlying cause di   | ven in Part I                          | 23e Did to                                | phacco use          | contribute to         | the cause of death?                                |
| ds,             | ires that<br>signed<br>d be de   | by                | Tax II. Other significant condition  | 713 contributing to death be                              | at not resulting in the t               | andenying occuse gi   | ven in react.                          | 1 🗆 1                                     |                     |                       | bably 4 Unknown                                    |
| Vital Records,  | w requir   | Completed         |  |   | **                                      |   |  |   |                     |                       |  |
| Rec             | has ge 2 s   | ld m              |  |   |   |   |  | 24a. Was<br>autop<br>perfo                | an<br>sy<br>rmed?   | prior to co<br>death? | opsy findings available<br>ompletion of cause of   |
| a               | ician: The<br>certificate ha<br>ector, page  |                   | 25. Was case referred,to medica  | 1   |   |   |  | 1□ Yes                                    | 2 No                | 1 ☐ Yes               | 2 □ No   |
|                 | iysiclan:<br>iis certific<br>director,   | o Be              | examiner?  | Hospital: 1 Inpatie                                       | nt 2 ☐ ER/Outpatie                      | nt 3DDOA Ot   | hor:                                   | eath (Check only o<br>Home 5 ☐ Resid      |                     | TOthor (Saga          | (6.)   |
| Division or     | ding Phy<br>n.<br>After this<br>funeral d  | n: To             | 27. Manner of Death  | 28a. Date of Inju   | ry 28b. Time o                          |   | 7 14d13llig                            | 28d. Describe                             |                     |                       | ny)  |
| <u>o</u>        | tending Reath. tor: After  | atio              | 2 atural 5 Pendir investi  | gation H 14 0 2   | Year) Injury                            | 3   | Yes 2 No                               | PATIEN                                    | 7                   | F-11                  |  |
| <u> </u>        | il or Attend<br>after death<br>I Director:<br>d in by the I  | Certification:    | 3 Suicide 6 Could 4 Homicide determ  | not be ined 28e. Place of injuitined building, etc.       | ury - At home, farm, st<br>c. (Specify) | treet, factory, office                                      |  | 28f. Location (S<br>City or Tox           | Street and N        | lumber or Rur         | ral Route Number,                                  |
| Ö               | itaio<br>rs aft<br>rai Di<br>led in  | Cer               |  | RESID   |   |   |  |   | omte                | ST Rin                | relegioned   |
|                 | To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial completely filled in by the funeral director, | edical            | (Check only 2 Medical  | ng Physician: To the best of<br>Examiner: On the basis of | f examination and/or in                 | th occurred at the t<br>nvestigation, in my                 | ime, date and pla<br>opinion, death oc | ce, and due to the<br>curred at the time, | cause(s) an         | id manner as a        | stated.<br>to the cause(s)                         |
|                 | the I  | Med               | one)   | and manner sta  | ated.                                   | 29c Licen   | se number                              |   | 29d Date s          | signed (Month,        | Day Vear)  |
|                 | , ,, ,   |                   | 29b. Signature and title of certifie   |   |   |   |  |   |                     |                       |  |
|                 | 5  |                   | 1/8/10cm   | who formated areas of a                                   | onth (Itam 00c) (T                      | Print)  | 1784                                   | (1  | AYK                 | 11 2                  | 7,2008   |
|                 | nes  |                   | 30. Name and a dress of person   | Power pieted cause of di                                  | eath (Item 23a) (Type                   | 1.D. 5  | OMenn                                  | rig lave                                  | Cumi                | perton                | 1 1 2008<br>WMD 2502                               |
|                 | Sta  | at <u>e</u>       | 31. Date filed (Month, Day, Year)  |   | ar's Signature                          |   | O TOTAL                                | 100/100/                                  | Conti               |                       | MI ZINA  |
|                 | Regist   |                   | MAY 0 2  | 2 2008  | w B. A                                  | barle   |  |   |                     |                       |  |

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** May 8, 2008 9:30 a Helen Forren Redmon /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Silver Spring
If Under 1 Year | ff Under 2 Hrs. | 8. Date of Birth (Month, Day, Year) Montgomery Birthplace (State or Foreign Country) 10701 Huntley Place 7. Age (In yrs. last birthday) 5. Social Security Number 578–32–1300 6. Sex **Funeral** 1 ☐ M 2 🖫 F 83yrs. Dec. 14, 1924 West Virginia Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State r than "natural", or iteme 23a or 28a-f ehow the Medical Exactinar roust be notified at 1 ☐ Yes 2 ☐ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Žip Code 10e. Street and Number USA 20902 10701 Huntley Place death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ No hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Year or Dates: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education permit. Pages 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natu
eny injury or other traumatic event, the Madical
angue. (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Forren Mamie Bostick 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10504 Meadowrick Lane, Bowie, MD 20721 James Redmon/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) May 13, Parklawn Memorial Park 2008 Rockville, Maryland 22 Name and Address of Facility Funeral Home Inc. 21. Sign yur of Funeral Service Licens 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) less than 3 mos **Physician** Non-Small Cell Lung Cancer /Medical Due to (or as a consequence of) Examiner ess than 3 mos Liver Metastasis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 🗌 Unknown 23e. Did tobacco use contribute to the cause of death? certificete hes been signed rector, pege 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 Yes 2 No 3 Probably 4 Unknown Hypertensian, Chronic Lung Disease Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an 1 ☐ Yes 2 No or Attending Physicien: After this certification funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) ဥ 1 Yes 2₺ No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 5 Pending investigation **X**≅Natural 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours of To the Funeral 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier d35996 May 9, 2008 6 1 mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Linda M. Burrell, MD 2730 University Blvd. #400, Wheaton, MD 20902 31. Date filed (Month, Day, Year) 2 32. Agistrar's Signature State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 William Jacob Robertson, Sr. 10:15 A May 11, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** WMHS-Memorial Campus Cumberland Allegany If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11/13/1917 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Months Days Min 1 M 2 □ F 90 214-05-8820 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 Is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at MD Allegany Cumberland 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1201 Holland Street 21502 USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No 1943— If Yes, Give Year or Dates: 1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🗓 No Specify Specify: ģ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Railroad Freight Agent permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 Is marked other 1 any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Dallas Robertson Vesta Nee Mav ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Robertson / son 1246 Maryland Avenue, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Vet Cem @ Rocky Gap 05/14/2008 Flintstone, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Dice 22. Name and Address of Facility Alams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) bec **Physician** /Medical Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events southing death). Examiner the death certificate be executed burial-tran and resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical as the MAY 12, 2008 IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant atter in the past 12 months? 1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy ō Year Month Day 4☐Pregnant at time of death 5 Other (specify) the 9□Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe I be c þ 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1□ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Yes 2 No 1 🕅 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred
Ground level Fall 27. Manner of Death 28b. Time of After t Certification: or Attending Injury □Natural 5 Pending investigation 0420 5-8-2008 1 🗌 Yes death. 28f. Location (Street and Jumber or Rural Route Number, City of Town, State) 2 Accident Director: 3 ☐ Suicide 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by City or Town, State) 4 Homicide 730 ha. Alkgany County Nursing + Rehab CH

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caute(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

Division or Vital Records, hours after Funeral To the Hospital within 24 h

Baltimore, Maryland 21215-0036

P.O. Box 68760

4+ MRI

Robert 31. Date filed (Month, Day, Year) MAY 1 3 2008

(Check only one)

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D. Cendo,

U.D.

940 Seton Drive, Cumberland, MD

29c. License number

D37970

29d. Date signed (Month, Day, Year)

May 12, 2008

Registrar

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 5:20 P.M 200x Carl Jack Snyder 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 XM 2 □ F July 24,1919 157-01-3615 88 New Jersey Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18804 Rolling Road 21742 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Maritai Status Black, White, etc. 1 ☐ Never Married 2 Married 2 No 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Accountant Commerce 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin H. Snyder Goldie A. Kaplan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte F. Snyder/Wife 18804 Rolling Road, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Mg Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 5/20/2008 Hagerstown, MD 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 1601 Pennsylvania Ave., Hagerstown, MD 21742 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) (or as a consequence of) Jecas if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ☐ Yes 2☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1□ Yes 2☑No 26. Place of Death (Check only one) Hospital: 1 Impatient

Physician /Medical Examiner

permit. Page Department o Important: If eny Injury or

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

by Physician/Medical

Completed

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Certification: To

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**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at

attending physician and for use as the burial-transit signed by the a peen has certificate

The law requires that the death certificate be execured Hospital or Attending Physician: To the Hosping.
Within 24 hours effer death.
To the Funeral Director: After this c

Division or Vital Records, P.O. Box 68760,

40 X1 State

IF FEMALE: 23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

12821 OAKHIR AVE. HAGERSTOWN MO21742 WAHEED MO

2008

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. gistrar's Signature

Registrar

Division or Vital Records, P.O. Box 68760,

|   |  | For State   | State o                                 | of Marylan   | -                                | artment of H                             |                                    | d Mental H                              | lygier                | ne                          | ~ ^                      | 17101                           |
|---|--|---|---|--|----------------------------------|--|------------------------------------|---|-----------------------|-----------------------------|--------------------------|---------------------------------|
|   |  | Registrar   | a Leoth                                 |  | Cei                              | rtificate of                             | Death                              | O Data of                               | Reg. I                | No.                         | 18_                      | 1/10                            |
| Physicia  | an   | Decedent's Name (First, Middle     Te   | e, <i>Last)</i><br>eanne                | Marie  | Cmå                              | ±1.                                      |                                    | 2. Date of Month                        | E                     | Day                         | Year                     | 3. Time of Death                |
| /Medic  |  | 4a. Facility Name (If not institution   |   |  | Smi                              | 4b. City, Town, o                        | r Location of D                    | May                                     |                       | 4c. County                  | 08                       | 11:58 P M                       |
| Examin  | er   |   | -                                       |  |                                  |  |                                    | eam                                     |                       |                             |                          |                                 |
| Funeral   | 28.  | Frederick Memo  | 6. Sex                                  | 7. Age (In yrs.  | last birthday)                   | Freder:                                  |                                    | Hrs. 8. Date of                         | Birth                 |                             | eric.  9. Birtho         | K.<br>lace (State or Foreign    |
| Director  |  | <b>2</b> 13-46-7205   | 1□M 2√2F                                | 63   | Yrs.                             | Months Days                              | Hours N                            | viin. (Month, Nov.                      | 28, Yes               | 1944                        | _Coun                    | nsylvania                       |
|   |  | Usual Residence of Decedent   |   |  |                                  |  |                                    | 12.077                                  |                       |                             | 1011                     | is y i varita                   |
| how   | _  | 10a. State 10b. County  |   | 10c. Cit   | y, Town or Lo                    | ocation                                  |                                    |   |                       |                             | 10                       | 0d. Inside City Limits          |
| Department of Health and Mental Hygiene. Important: If Item 27 is merked other than "neturel", or Items 23e or 28e-f show eny Injury or other traumatic event, the Medical Examiner must be notified at once. | cto  | Maryland Frede  | rick                                    | F  | rederi                           | ck                                       |                                    |   |                       |                             |                          | 1 □ Yes 2 No                    |
| or 28   | Dire   | 10e. Street and Number  |   |  |                                  | 10f. Zip Code                            |                                    |   |                       | Citizen of W                | hat Coun                 | try?                            |
| 23e<br>ust b  | ral  | 5909 Bryan Dri  | ve                                      |  |                                  | 21703                                    |                                    |   | U                     | J.S.A.                      |                          |                                 |
| tems<br>ner m   | Funeral Director   | 11. Marital Status  | Armed Fo                                |  | .S. 13.                          | Was Decedent of H<br>If Yes, specify Cub | lispanic Origin'<br>an, Mexican, P | ? (Specify Yes or<br>uerto Rican, etc.) | No-                   |                             | - America<br>, White,    |                                 |
| amir o  | by F   | 1 ☐ Never Married 2 ☐ Marri<br>3 ☐ Widowed 4 ☐ Divorced   | ied 1 ☐ Yes<br>If Yes, Gi<br>Year or D  | ive  | 1                                | 1 ☐ Yes 2 ☐ No                           | Specify:                           |   |                       | Specify:                    | Whit                     | t o                             |
| turel<br>al Ey  | a pe   | 15. Deceden   |   | Jales.   |                                  | dent's Usual Occup                       | ation                              |   | 16h                   | . Kind of Bu                |                          |                                 |
| edic  | olet   | (Specify only higher  | st grade completed)                     |  | (Give                            | kind of work done DO NOT use retire      | during most of                     | working                                 | 100                   | . Killa Ol Bu               | SIII es s/III (          | lustry                          |
| the N   | Completed  | Elementary/Secondary (0-12) College (1-4or 5+)  12 Medical Secretary Health Care  |   |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| othe<br>ent,  | Be C   | 17. Father's Name (First, Middle,   | Last)                                   |  |                                  | TCGT OCCI                                |                                    | Name (First, Mid                        |                       |                             |                          |                                 |
| fenta<br>rked<br>tic ev   | To B   | Nelson War  | ren Boyle                               | S  |                                  |  | Mary A                             | Ada Cham                                | ber1                  | in                          |                          |                                 |
| and N<br>uma  |  | 19a. Informant's Name/Relations   | hip (Type. Print)                       |  | 19b. Maili                       | ng Address (Street                       | and Number o                       | or Rural Route Nu                       | mber, Cit             | ty or Town,                 | State, Zip               | Code)                           |
| alth a  |  | Wanda L. Mills  | , daughte:                              | r  | 2538                             | Kaetzel F                                | Road, Ki                           | noxville                                | , MD                  | 2175                        | 8                        |                                 |
| item<br>roth  |  | 20a. Method of Disposition  |   |  | Place of Dispo                   | osition (Name of matory or other place   | ce)                                | Date                                    | 20c.                  | Location -                  | City or To               | wn, State                       |
| nt: if  |  | 1 ☐ Burial 2 ② Cremation 4 ☐ Donation 5 ☐ Other (S  |   |  |                                  |  |                                    | y 22, 20                                | 08                    | Smith                       | sburg                    | g, MD                           |
| partir<br>sorta<br>/ inju   | Smithsburg Crematory May 22, 2008 Smithsburg  21. Signator of Funeral Service Licensee  MO0255  Smithsburg Crematory May 22, 2008 Smithsburg  Reeney and Address of Facility for PA Funeral Home |   |   |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| 8 1 2   |  | 1 Jan E   | Dreft                                   | MO0255   |                                  | 106 East                                 | Church                             | St., Fr                                 | eder                  | ar no                       | MD 2                     | 21701                           |
|   |  | 23a. Part1. Enter the disease, or shock, or heart failure. List   | complications that                      | caused the deat  |                                  |  |                                    |   |                       |                             |                          | Approximate<br>Interval Between |
| ysician   |  | Immediate Cause (Final  | 1                                       |  | mall                             | SCELL                                    | 1,                                 | 1016 1                                  | Pn                    | CEP                         |                          | Onset and Death                 |
| Medical   |  | disease or condition resulting in death)  | -                                       | (or as a conseq  |                                  | 5 ( C C C C                              |                                    | 77707                                   | <i>-</i> )/V          |                             |                          | MONTH.                          |
| aminer  |  |   |   |  | ŕ                                |  |                                    |   |                       |                             |                          |                                 |
| ***   | ner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury                                       | b. — Due to                             | (or as a conseq  | uence of):                       |  |                                    |   | -                     |                             |                          |                                 |
| physician and<br>s the burial-transit   | Examiner   | that initiated events   | C                                       |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| an ai<br>irial-t  | EX   | resulting in death) Last  | Due to                                  | (or as a conseq  | uence of):                       |  |                                    |   |                       |                             |                          |                                 |
| hysic<br>he bu  | dical  |   | d                                       |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| 77. 67  | 0  | IF FEMALE:  | T                                       |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| attending p   | Physician/M  | 23b. Was decedent pregnant  | 23c. If yes, ou<br>1□Live               | tcome pf pregnation that the property of the p |                                  | ⊒Ectopic pregnanc                        | y                                  |   |                       |                             | e of delive              | ,                               |
| he at   | sici   | in the past 12 months?<br>1 □ Yes 2 □ No  | 4□Pregi<br>9□Unkn                       | nant at time of o  |                                  | Other (specify)                          |                                    |   | _                     | Moi                         | ıtrı                     | Day Year                        |
| i signed by the a<br>Id be detached f   | Ph   | 9 Unknown   | 4 7 1                                   |  |                                  |  |                                    |   |                       | 1                           |                          |                                 |
| igne<br>be d  | þ  | Part II. Other significant condition  | ons contributing to a                   | leath but not res  | ulting in the u                  | inderlying cause giv                     | en in Part I.                      |   |                       |                             |                          | e cause of death?               |
| should t  | Completed  |   |   |  |                                  |  |                                    | - '                                     | ∐ Yes                 | 2 No                        | 3 Prob                   | ably 4 □Unknow                  |
| has b   | ed l   |   |   |  |                                  |  |                                    |   | vas an<br>utopsy      |                             |                          | psy findings availabl           |
| page  | Son  |   |   |  |                                  |  |                                    | P                                       | erformed<br>s 2 13    | ?   d                       | eath?<br>□Yes            |                                 |
| certificate<br>rector, pag  | Be (   | 25. Was case referred to medica examiner?   |   |  |                                  | - 1                                      | 26. Place of                       | Death (Check or                         | ily one)              |                             |                          |                                 |
| his o   | 으  | 1 Yes 2 No  | Hospital: 1                             | 1npatient 2□   | ER/Outpatier                     | nt 3 DOA Oth                             | er: 4 🗆 Nursir                     | ng Home 5□F                             | Residence             | 6 □Oth                      | er (Specify              | v)                              |
| offer 1   |  | 27. Manner of Death 1 ☑ Natural 5 ☐ Pendin  | 28a. Date<br>(Mon                       | of Injury<br>oth, Day Year)  | 28b. Time o<br>Injury            | of 28c. Inju                             | ry at<br>rk?                       | 28d. Descri                             | be how in             | njury occurr                | ed                       |                                 |
| or: A   | Certification:   | 2 ☐ Accident investig   | gation                                  |  |                                  | M 1 □                                    | Yes 2 □ No                         |   |                       | _                           |                          |                                 |
| irect<br>n by   | ij   | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide determ  | ined   28e. Place                       | e of injury - At h<br>ling, etc. <i>(Speci</i> i   | ome, farm, st<br>fy)             | reet, factory, office                    |                                    | 28f. Location<br>City or                | n (Street<br>Town, St | t and Numbe<br>tate)        | er or Rura               | l Route Number,                 |
| within 24 hours after death.  To the Funeral Director; After this certifice completely filled in by the funeral director, t   |  |   |   |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| Fune<br>Fune<br>tely fi   | edical   | (Check only 2 Medical   | ng Physician: To the Examiner: On the b | pasis of examina   | owledge, deat<br>ation and/or in | th occurred at the tinvestigation, in my | me, date and popinion, death       | place, and due to<br>occurred at the ti | the cause<br>me, date | e(s) and ma<br>and place, a | nner as st<br>and due to | ated. the cause(s)              |
| thin 2<br>the<br>mple   | Med  | one)  29b. Signature and title of certifie  |   | ner stated.  |                                  | 29c. Licens                              | e number                           |   | 204                   | Date elene                  | Manak                    | Day Voorl                       |
| ĭ ¥ ¥ 8   |  | 200. Signature and title of certifie  | 1                                       | 25   |                                  |  |                                    | / 6                                     |                       | Date signed                 |                          |                                 |
|   |  | YN  |   | 1/5  |                                  |  | 1614                               | 10                                      |                       | 1817)                       | , 2                      | 0, 2008                         |
| 10  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Gaffar Syed, M.D., 801 Toll House Ave., Frederick, MD 21701 |   |  |                                  |  |                                    |   |                       |                             |                          |                                 |
| 1   | •  | Gaitar Sye  |   | 801 To1  |                                  | se Ave.,                                 | rederi                             | .ck, MD 2                               | ZI /01                | L                           |                          |                                 |
| Sta<br>Registra   |  | MAN A P 2   | 000                                     | Logistial a Signa  | <i>■</i>                         |  |                                    |   |                       |                             |                          |                                 |
|   | 001  | MAY 2 7 2   | JUO NEE                                 | un St  | Good                             |  |                                    |   |                       |                             |                          |                                 |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

|                                |   |                     | State of Maryland / Department  1 - State Registrar Certificate  |   | , ,                                  | 0 0 0 0 0   | 17100  |
|--------------------------------|---|---------------------|--|---|--------------------------------------|---|--|
|                                |   |                     | Registrar  1. Decedent's Name (First, Middle, Last)  | Or Douter                                   | 2. Date of Death                     |   | 3. Time of Death                                   |
| c .                            | Physici<br>/Medic   |                     | Louise Schultz   |   | May 20, 2                            | Day Year<br>008                                   | 12:55 A. M   |
| 3                              | Examin  |                     |  | wn, or Location of Death                    |                                      | 4c. County of Death                               |  |
| -                              | Funeral   |                     | Glade Valley Nursing Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1  | Valkersville<br>Year   If Under 24 Hrs.     | 8. Date of Birth (Month, Day,        | Frederic  9. Birth                                | place (State or Foreign                            |
| ı                              | Director  |                     | 217-28-0994 1 M 2 XF 76 Yrs. Months E  | Days Hours Min.                             | (Month, Day,<br>November 1           | 76ar) Cou<br>.6, 1931 Ma                          | intry)<br>ryland                                   |
|                                | w w   |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   |                                      |   | 10d. Inside City Limits                            |
|                                | Maryli<br>f sho   | tor                 | Maryland Frederick Freder  | rick  |                                      |   | 1 □Yes 2 No  |
|                                | h the   | irec                | 10e. Street and Number 10f. Zip C  | ode   | 10                                   | g. Citizen of What Cou                            | intry?   |
|                                | ath wil   | ral                 |  | 21702                                       |                                      | United St   | ates   |
| 980                            | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>deat Evan Live Invest by profithed at   | by Funeral Director | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give Year or Dates:  | nt of Hispanic Origin? (Sp                  | ecify Yes or No-<br>Rican, etc.)     | 14. Race - Amer<br>Black, White<br>Specify: WI    |  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, it is Marical Exact increments by rediffical an once. | Completed           | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  Homemake   | done during most of work<br>retired)        | ing 1                                | 6b. Kind of Business/II  Own Home                 |  |
| land 2                         | uld be filed<br>Aental Hygi<br>rked other<br>tic event, ti  | To Be Co            | 17. Father's Name (First, Middle, Last)  Glenn Lee Putman  | 18. Mother's Name                           | e (First, Middle, M<br>Susan Harne   | aiden Surname)                                    |  |
| , Mary                         | is 1 and 2 shou<br>of Health and N<br>Item 27 is mai<br>other trauma  |                     |  | Street and Number or Rur<br>7 Road, Frederi |                                      | •   | ip Code)   |
| imore                          | Pages 1:<br>ment of He<br>ant: If Iten<br>ury or oth  |                     | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)  20b. Place of Disposition (Name cemetery, crematory or othe Rocky Springs Cemetery)   |   |                                      | oc. Location - City or Trederick, Ma              |  |
| Balt                           | permit. Departimport any inj  |                     | . / / / /  | Address of Facility Ke<br>Church Street,    |                                      |   |  |
| En                             | Physician   |                     | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  |   |                                      | st,   | Approximate<br>Interval Between<br>Onset and Death |
|                                | /Medical<br>Examiner  |                     | Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):   | STYPETT                                     | -                                    |   | years  |
| 68760, 77                      | ificate be executed<br>g physician and<br>is the burial-transit   | al Examiner         | Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  |   |                                      |   | Υ  |
| O. Box                         | The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   SNo 9   Unknown   Unkno |   |                                      | 23d. Date of deli<br>Month                        | very<br>Day Year                                   |
| rds, P.                        | w requires that<br>s been signed b<br>should be det   | by                  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause  | se given in Part I.                         |                                      | acco use contribute to<br>s 2 <b>∑</b> No 3 ☐ Pro | the cause of death?                                |
| al Reco                        | ysician: The law re<br>lis certificate has bee<br>director, page 2 sho  | Completed           | 25. Was case referred to medical   |   |                                      | prior to c<br>death?<br>No 1 Yes                  | opsy findings available ompletion of cause of      |
| Division of Vital Records,     | ding Pt<br>J.<br>After th<br>funeral  | tion: To Be         | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  27. Manner of Death 1 Natural 5 Pending (Month, Day, Year)  28. Date of Injury 28b. Time of Injury 28c.   | 1 3   |                                      | nce 6 Other (Spec                                 | ify)   |
| Divisi                         | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | Certification: To   | 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, o building, etc. (Specify)   |   | 28f. Location (Str.<br>City or Town, | eet and Number or Ru<br>State)                    | ral Route Number,                                  |
|                                | the Hospi<br>nin 24 hou<br>the Funer<br>npletely fill   | Medical             | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.  | n my opinion, death occur                   | red at the time, da                  | te and place, and due                             | to the cause(s)                                    |
|                                | Mitt  | 2                   |  | License number                              | 29                                   | d. Date signed (Month                             | , Day, Year)                                       |
|                                | <i>v</i>  |                     | 30. Name and address of person who competed cause of death (Item 236) (Type, Print)  Lloyd E. Halvorson, M.D. 1475 Taney Avenue, #204, Fi  | rederick, Maryl                             | and 21702-                           | ·5127   |  |
|                                | Sta<br>Registr  |                     | 31. Date filed (Month, Day, Year) 2008 32 Registrar's Signature  |   |                                      |   |  |

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|  |  |                | For<br>State<br>Registrar   | State of Marylan   | _                               | artment of F<br>rtificate of                  |   | -                                  | giene<br>Reg. No. 🕻        | 2008                          | 17103  |
|--|--|----------------|---|--|---------------------------------|---|---|------------------------------------|----------------------------|-------------------------------|--|
| F  | Physici  |                | 1. Decedent's Name (First, Middle, Las<br>David Starks                        | st)  |                                 |   |   | 2. Date of De<br>Month<br>May 5    | Day                        | Year<br>8                     | 3. Time of Death 7:58 P M                        |
|  | Medio/<br>Examin   |                | 4a. Facility Name (If not institution, give                                   |  |                                 |   | r Location of Death                         |                                    | 4c. Co                     | ounty of Death                | 1  |
|  | _ iotac <u></u>  |                | Southern Maryla  5. Social Security Number 6. S                               |  | last hirthday)                  | Clin  | ton If Under 24 Hrs.                        | 8. Date of Bir                     |                            |                               | George's   |
|  | uneral<br>rector   | V-1            |   | M 2□F 46   | Yrs.                            | Months Days                                   | Hours Min.                                  | Jan 24                             | v. Year)                   | 2 Wasi                        | place (State or Foreign<br>intry)<br>nington, DC |
| aryland  | show<br>d at   | Į.             | 10a. State 10b. County  | 10c. City  | y, Town or Lo                   | cation  |   |                                    |                            |                               | 10d. Inside City Limits                          |
| he Ma  | 28a-f  | Director       | District of Co.   | lumbia W   | ashing                          |   |   | ī                                  | 10 0:::                    | (147)                         | 1√GYes 2□No                                      |
| with 1   | la or i  |                | 1904 - M Street,  | NE #1  |                                 | 10f. Zip Code<br>20002                        |   |                                    |                            | n of What Cou<br>ted Sta      | ·  |
| death  | ms 2;  | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U.  | S. 13.1                         |   | lispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No                    |                            | . Race - Amer                 | ican Indian,                                     |
| Maryiand 21215-0036 td 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. | cd other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | þ              | 1 Never Married 2 Married 3 Widowed 4 Divorced                                | Armed Forces? 1 ☐ Yes 2點 No If Yes, Give Year or Dates:  |                                 | 1 ☐ Yes 21 No                                 | an, mexican, Puerro<br>Specify:             | Hican, etc.)                       |                            | Black, White                  | , etc.<br>Lack                                   |
| 5-0<br>72 hc   | "natu<br>dical   | etec           | 15. Decedent's Ec   | lucation<br>de completed)  | 16a. Dece                       | dent's Usual Occup<br>kind of work done       | ation<br>during most of work<br>d)          | ring                               | 16b. Kind                  | of Business/I                 | ndustry  |
| within ene.  | than<br>he Me  | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)   |                                 | ehouse Er                                     |   |                                    | Dr.                        | ivate                         |  |
| d 21   | other<br>ent, tl   | Be Co          | 17. Father's Name (First, Middle, Last)                                       | )  | war                             | chouse in                                     | 18. Mother's Name                           | e (First, Middle                   |                            |                               |  |
| should be and Mental   | rked of  | To B           | Billy Blake   |  |                                 |   | Waun  | ita D.                             | Starks                     | S                             |  |
| Taryla<br>2 should<br>and Men  | 00 =   |                | 19a. Informant's Name/Relationship (  | Type. Print)   | 19b. Mailir                     | ng Address (Street                            | and Number or Rur                           | al Route Numb                      | er, City or T              | own, State, Z                 | ip Code)   |
| and and lealth   | item 27 i<br>other tre   |                | Antonio Williams  |  | 1516                            | Ho1brool                                      | Street,                                     | NE Was                             |                            |                               |  |
|  |  |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐                       | memovar nom state  | -                               | sition (Name of<br>matory or other place      |   | Date                               |                            | tion - City or 1              |  |
| Itir Pe  | Important: If<br>any Injury o<br>once.   |                | 1 □ Donation 5 □ Other (Specify 21. 3 gnature of Fur eral Service Liser       | ′′   |                                 | Mem. Cemt                                     | ss of Facility S                            | 12, 200<br>tewart                  |                            |                               |  |
| Balt<br>permit.<br>Departr   | any  |                | all with  | The words  |                                 |   | ing Road,                                   |                                    |                            |                               |  |
|  |  |                | 23a. Parti. Enter the disease, or com<br>shock, o) heart failure. List only   | plications that caused the death   | n. Do not ent                   | er the mode of dyir                           | ng, such as cardiac                         | or respiratory a                   | rrest,                     |                               | Approximate<br>Interval Between                  |
| Phys   | sician   | 1              | Immediate Cause (Final disease or condition                                   | Acute V  | Tunca                           | rchal In                                      | kutem                                       |                                    |                            |                               | Onset and Death                                  |
|  | edical<br>miner  |                | resulting in death)   | Due to (or as a consequ  | ueo e of):                      |   |   |                                    |                            |                               |  |
| LAGI   | Marie 1  | -              | Sequentially list conditions,   | b. Lus to (or as a consequ   | er en en                        |   |   |                                    |                            |                               |  |
| peti   | nsit   | nine           | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Das to for as a consesqu   | 131100 317.                     |   |   |                                    |                            |                               |  |
| ),<br>execu  | n and<br>iaf-tra   | Examiner       | that initiated events<br>resulting in death) Last                             | CDue to (or as a consequ   | uence of):                      |   |   |                                    |                            |                               |  |
| 68760,<br>ificate be executed  | physician and<br>s the burial-transit  | edical         |   | d  |                                 |   |   |                                    |                            |                               |  |
|  | ng ph<br>e as th   | Med            | IF FEMALE:  |  |                                 |   |   |                                    |                            |                               |  |
| OrdS, P.O. BOX<br>requires that the death cert   | the attending<br>ched for use as   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No                | 23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown | Ideath 3□                       | Ectopic pregnancy<br>Other <i>(specify)</i>   |   |                                    | 230                        | d. Date of deli<br>Month      | very<br>Day Year                                 |
| that   | been signed by the<br>should be detached   |                | Part II. Other significant conditions of                                      | ontributing to death but not resu  | ulting in the ur                | nderlying cause giv                           | en in Part I.                               | 23e. Did t                         | obacco use                 | contribute to                 | the cause of death?                              |
| rds<br>quires  | uld be   | ed by          |   |  |                                 |   |   | 10                                 | Yes 2 <mark>⊡</mark> 1     | No 3□ Pro                     | obably 4 ∐Unknown                                |
| 19 >   | as bee<br>2 sho  | Completed      |   |  |                                 |   |   | 24a. Was                           |                            |                               | topsy findings available                         |
| r e  | page 2 s   | mo.            |   |  |                                 |   |   | autoj<br>perfo<br>1∐ Yes           | rmed?                      | death?<br>1 ☐ Yes             | ompletion of cause of<br>2 No                    |
| /ITa   | certificate<br>ector, pag  | Be             | 25. Was case referred to medical examiner?                                    |  |                                 |   | 26. Place of Deat                           |                                    |                            |                               |  |
| OF Physi   | this o   | 2              | 1 Yes 2 No  27. Manger of Death   | Hospital: 1 ☐ Inpatient 2 ☐  28a. Date of Injury   | ER/Outpatien                    |   | 4 LI Nursing Ho                             |                                    |                            |                               | ify)   |
| on<br>Fire   | : After  | Certification: | 1 Natural 5 Pending 2 Accident investigation                                  | (Month, Day Year)  | Injury                          | Wor   | y at<br>k?<br>Yes 2 □ No                    | 28d. Describe                      | now injury o               | ccurred                       |  |
| or Attending after death.  | ector<br>by the  | ifica          | 3 Suicide 6 Could not be determined   | 28e. Place of injury - At ho<br>building, etc. (Specify  | me, farm, str                   | eet, factory, office                          |   |                                    |                            | Number or Ru                  | ral Route Number,                                |
| tal or   | ed in  | Cert           | /   | building, etc. (opean)   |                                 |   |   | City or To                         | vn, State)                 |                               |  |
| DIVISION OF VITA To the Hospital or Attending Physician: within 24 hours after death.                          | he Funel<br>pletely fil  | Medical        | 29a. Certifier 1 Certifying Ph<br>(Check only one) 1 Medical Exam             | ysician: To the best of my kno-<br>niner: On the basis of examina-<br>and manner stated.       | wledge, death<br>tion and/or in | n occurred at the tir<br>vestigation, in my o | ne, date and place,<br>pinion, death occur  | and due to the<br>red at the time, | cause(s) ar<br>date and pl | nd manner as<br>lace, and due | stated.<br>to the cause(s)                       |
| Tot  | 3  | Σ              | 29b. Signature and the or certifier   | ms   |                                 | 29c. Licens                                   | 55120                                       |                                    | 29d. Date s                | 6 h                           | Day, Year)                                       |
|  | \$e  |                | 30. Name and address of person who a  | 1328 Southern  | avenue                          |   | 310 Washin                                  | s for M                            | 2003                       | 2                             |  |
|  | Sta  | -              | D. D. B. B. L. C. B. M. D. M. L.  |  |                                 |   | - PV  | 1,0,000                            |                            |                               | -  |
| F  | Registr  | ar             | MAY 1 3 2008  | 32. Hegistrar's Signa  | WE)                             | <del></del>                                   |   |                                    |                            |                               |  |

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|                |   |                     | 1 - For<br>State<br>Registrar   | State of Maryland  |                               | tificate of l  |   | vieritai my                           | Reg. No.                  | 2008  | 3 17104  |
|----------------|---|---------------------|---|--|-------------------------------|--|---|---------------------------------------|---------------------------|---|--|
|                | Physici   | an                  | 1. Decedent's Name (First, Middle, Last)  |  |                               |  |   | 2. Date of D<br>Month                 | eath<br>Day               | Year  | 3. Time of Death                                 |
|                | /Medic  | al                  | Juanita Smith   |  |                               | 4. C: T  |   | May 7                                 |                           |   | 10:10 P M  |
|                | Examin  | er                  | 4a. Facility Name (If not institution, give s   |  |                               |  | Location of Deatl                       | 1                                     |                           | County of Dea                                 |  |
| - 000          | Funeral   | 1                   | 5113 Emerson Stree  5. Social Security Number 6. Sex  |  | st birthday)                  |  | If Under 24 Hrs.                        | 8. Date of Bi                         | rth                       | 9. Bir  | George's thplace (State or Foreign ountry)       |
|                | Director  |                     | 579-16-3586   | M 2♥ F 86  | Yrs.                          | Months Days Hours Min. (Mont. Feb                              |   |                                       | , 192                     | 2 Cha   | ttanooga, TN                                     |
|                | /land   |                     | 10a. State 10b. County  | 10c. City,   | Town or Loc                   | cation   |   |                                       |                           |   | 10d. Inside City Limits                          |
|                | a-f st  | ctor                | MD Prince Ge  | eorge's Hya  | ttsvil                        | L1e  |   |                                       |                           |   | 12⊈Yes 2 No                                      |
|                | or 28   | Dire                | 10e. Street and Number  |  | -                             | 10f. Zip Code  |   |                                       | 10g. Citiz                | en of What Co                                 | ountry?  |
|                | s 23a   | by Funeral Director | 5113 Emerson Stree  |  | 140.14                        |  | 20781                                   | 7 1/                                  | - 1 4                     | USA   | -i Indian  |
|                | ter de  | -un                 | 11. Marital Status 1 ☐ Never Married 2 ☐ Married  | 12. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ☐ Yes 2 ☒ No                         | 13. V                         | Vas Decedent of H<br>Yes, specify Cuba                         | an, Mexican, Puer                       | to Rican, etc.)                       | -   '                     | <ol> <li>Race - Ame<br/>Black, Whi</li> </ol> |  |
| 21215-0036     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | l by I              | 3 ☑ Widowed 4 ☐ Divorced  | If Yes, Give<br>Year or Dates:   | 1                             | ☐Yes 2M No   | Specify:                                | _                                     |                           | Specify:                                      | White  |
| 5-0            | 72 hc<br>"natu<br>adical  | Completed           | 15. Decedent's Educ<br>(Specify only highest grade  |  | 16a. Deced                    | ent's Usual Occup<br>kind of work done o<br>OO NOT use retired | ation<br>during most of wo              | rking                                 | 16b. Kin                  | d of Business                                 | /Industry  |
| 121            | within<br>ene.<br>than<br>he Me   | duo                 | Elementary/Secondary (0-12)   | College (1-4or 5+)   | iite. L                       | Housewif   | _                                       |                                       |                           | Orana II                                      |  |
| <b>d</b> 2     | filed<br>Hygi<br>other<br>ent, tl   |                     | 17. Father's Name (First, Middle, Last)   |  |                               | nousewil   | 18. Mother's Nar                        | ne (First, Middle                     | , Maiden S                | Own H<br>Surname)                             | one  |
| lan.           | Ald be Alental rked of the ev   | To Be               | (Unavailable) Od  | dum  |                               |  | Bessi                                   | e L. (                                | Unava                     | ilable  | )  |
| Maryland       | 2 sho<br>and h<br>Is ma<br>auma   | •                   | 19a. Informant's Name/Relationship (Typ   |  |                               | g Address (Street  |   |                                       |                           |   |  |
|                | l and<br>lealth<br>im 27<br>her tr  |                     | Robert Curtis Smit  |  |                               | Jayston  | e Dr., S                                | ilver S                               |                           |   | 20905  |
| Baltimore,     | nt of h   |                     | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re   | emoval from State  | metery, cirem                 | natory or other plac   | i                                       |                                       |                           | cation - City or                              |  |
| Ħ              | artme<br>artme<br>ortant<br>Injury  |                     | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License  |  |                               | n Cemete:  |   | 0/08                                  |                           |   | , Maryland<br>Lmore Ave.                         |
| Ba             | permi<br>Depar<br>Impor<br>any Ir<br>once   |                     | 1/4/  | A.   | 1                             |  | ,                                       | ne, P.A.                              |                           |   | le, MD 20781                                     |
| r              | 3<br>Mi   |                     | 23a. Parti. Enter the disease, or complic<br>shock, or heart failure. List only on  | cations that caused the death.   |                               |  |   |                                       |                           |   | Approximate<br>Interval Between                  |
| 6              | Physician   |                     | Immediate Cause (Final disease or condition   | Coronary ar  |                               |  |   |                                       |                           |   | Onset and Death 5 years                          |
|                | /Medical<br>Examiner  |                     | resulting in death)   | Due to (or as a conseque   | ,                             |  |   |                                       |                           |   | _  |
| н              | Lammer  | _                   | Sequentially list conditions, b   | . Congestive  Due to (or as a conseque   |                               | failure  |   |                                       |                           |   | 5 years  |
|                | uted<br>Insit   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseque   | nice oi).                     |  |   |                                       |                           |   |  |
| oʻ             | rificate be executed ig physician and as the burial-transit   |                     | resulting in death) Last  | Due to (or as a conseque   | ence of):                     |  |   |                                       |                           |   |  |
| 68760,         | ate be<br>hysicia<br>he bu  | edical              | <b>€</b> d  | l  |                               |  |   |                                       |                           |   |  |
| _              |   |                     | IF FEMALE:  | 0-11   |                               |  |   |                                       |                           |   |  |
| Вох            | eath c<br>attenc<br>for us  | cian/               | in the past 12 months?  | 3c. If yes, outcome pf pregnand 1□Live birth 2□Fetal of 4□Pregnant at time of dea        | leath 3□                      | Ectopic pregnancy<br>Other (specify)                           | /                                       |                                       | 2                         | 3d. Date of de<br>Month                       | elivery<br>Day Year                              |
| P.O.           | The law requires that the death cer<br>te has been signed by the attendin<br>age 2 should be detached for use :   | by Physician/IV     | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 9☐Unknown  |                               | - Carter (Speeding)  |   |                                       |                           |   |  |
| ď.             | s that<br>gned b  | y Pl                | Part II. Other significant conditions con   | ntributing to death but not result   | ing in the un                 | iderlying cause giv  | en in Part I.                           | 23e. Did                              | tobacco us                | se contribute t                               | to the cause of death?                           |
| Vital Records, | equire<br>en sig<br>ould b  | edk                 |   |  |                               |  |   | 1 🗆                                   | Yes 2                     | ]No 3∏F                                       | robably 4 Unknown                                |
| ecc            | m (0 o)   | Completed           |   |  | _                             |  |   | 24a. Wa                               | DDSV                      | 24b. Were a                                   | utopsy findings available completion of cause of |
| <u>=</u>       | Ø □   | Соп                 |   |  |                               |  |   | per<br>1∏ Yes                         | ormed?<br>2 No            | death?  | s 2 No   |
| Zit.           | Physician:<br>r this certific<br>ral director,  | Be                  | 25. Was case referred to medical examiner?  | Hospital:  |                               | Oth  | 26. Place of Dea                        |                                       |                           |   |  |
|                | Phys<br>rthis<br>ral di   | : To                | 1 ☐ Yes 2 ☑ No  | I □ Inpatient 2 □ E  | R/Outpatient<br>28b. Time of  | I OLI DOA  | 4 Li Nursing F                          | dome 5 Nescribe                       |                           |   | ecify)   |
| ion            | Attending<br>r death.<br>ector: After   | tion                | 1X Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)  | Injury                        | 28c. Injur<br>Wor<br>M 1 🗆                                     | k?<br>Yes 2∐No                          |                                       |                           |   |  |
| Division or    | ar dea<br>rector  | Certification:      | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of injury - At hom building, etc. (Specify)                                   | ne, farm, stre                | eet, factory, office   |   | 28f. Location                         | (Street and               | d Number or F                                 | Bural Route Number,                              |
| Ö              | ital or<br>irs afte<br>ral Dir<br>led in l  | Cert                |   |  |                               |  |   |                                       |                           |   |  |
|                | To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral  | Medical             | 29a. Certifier 1 Certifying Phys<br>(Check only one) 2 Medical Examir   | sician: To the best of my know<br>ner: On the basis of examination<br>and manner stated. | ledge, death<br>on and/or inv | occurred at the tile<br>estigation, in my o                    | me, date and plac<br>opinion, death occ | e, and due to th<br>urred at the time | e cause(s)<br>e, date and | and manner a<br>place, and du                 | is stated.<br>ie to the cause(s)                 |
|                | within<br>To the<br>comp  | Me                  | 29b. Signature and title of certifier   | 201  |                               | 29c. Licens  |   |                                       | 29d. Date                 | e signed (Mor                                 | th, Day, Year)                                   |
|                | EID   |                     | ) V -   | >1, LAN  |                               | DIS  | 9897                                    |                                       | Į.                        | 5.10.   | 98   |
| •              | Je .  |                     | 30. Name and address of person who co   |  |                               | *  | MD 207                                  | 70                                    |                           |   |  |
|                | Sta   | te                  |   | 9A Hanover Pkw<br>32. Registrar's Signatu  | -                             | eembelt,   | MD 207                                  | / 0                                   |                           |   |  |
|                | Registi   |                     | 31. Date filed (Month, Day, Year) MAY 1 3 2008  | and It from  | de la                         |  |   |                                       |                           |   |  |
| DH             | IMH 17 Rev 1/2  | 001                 |   |  |                               |  |   |                                       |                           |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** May 10, 2008 00:41 Elizabeth B. Shannon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 € F 1/1/1925 Director 83 Long Island, NY 577-70-2154 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at 17 Yes 2 No Director Maryland | Prince George's Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20774 United States 1502 Robert Lewis Ave. Funeral within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify Specify:Black ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Property Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mildred Young 2 Jimmy Bradshaw 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1502 Robert Lewis Ave. Upper Marlboro, Md. 20774 Robin Cole / Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/16/2008 Suitland, Maryland incoln Memorial 21. Sign xure of Facera Servic Licensee 22. Name and Address of Facility Pope Funeral Homes, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only on a care on he death. Do not enter the mode of dying, such as cardiac or respiratory e on each line Immediate Cause (Final **Physician** rouss resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner death certificate be executed and Due to (or as a consequence of) attending physician a for use as the burial-P.O. Box 68760 by Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) □Yes 2⊠No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed page this certificate 2 No 2 No 1 Yes or Vital the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 1 Tes 1/Minpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Within 24 hours after deau...
To the Funeral Director: After Certification: Injury Division 1 Natural (Month, Day Year) 5 ☐ Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

36

State Registrar

29b. Signature and title of certifier

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ress of person who completed cause of death (tem 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 💪 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year 55 P M 100C 2008 100 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9 rince TEOFIE'S If Under 24 Hrs 8. Date of Birth (Month, Day, May 13, Social Security Number Age (In yrs. fast birthday Birthplace (State or Foreign Country) **Funeral** Days Hours 1**½** M 2□ F Yrs 1924 578-22-2665 83 Pennsylvania Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notifled at 1 X Yes 2 No Directo Prince George's Maryland Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 USA Funeral 6402 Hardwood Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ∰Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No 1943-Maryland 21215-0036 1 ☐ Yes 2 ☐ No White Specify: Completed by 3 Widowed 4 Divorced 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Reprograghics Printer Federal Government other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Emilie Kirner Elwood William Schuler, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20706 6402 Hardwood Drive, Lanham, MD Lucille Schuler - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 5/13/2008 Brentwood, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Fort Lincoln Funeral Home 20722 3401 Bladensburg Road, Brentwood, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical the as IF FEMALE: for use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 certificate death? 2 No 1∐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Morne 12 1 Natural 28a. Date of Injury (Month, Day Year) Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 ☐ Pending investigation Injury 1 Yes 2 🗆 No death. 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 29a. Certifier 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year)

State Registrar

10A

DHMH 17 Rev 1/2001

MAY 1 3 2008

30. Name and address of person

31. Date filed (Month, Day, Year)

32. Registrar's Signature

MDD60611

8118 GOOD LUCK ROAD

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LANHAM & BOTOL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Year May 2008 ay Schlorb 4:00 A **Physician** Mae Margaret /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Temple Hills 4112 25th Avenue If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | March 5, 1916 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 ☐ M 2 🕮 92 Washington, DC 579-92-2778 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County or Items 23e or 28a-f show injury or other treumatic event, the Medical Examinar must be notified at 1 □Yes 2XXXIO Maryland Prince George's Director Temple Hills 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4112 25th Avenue 20748 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 查內 No If Yes, Give Year or Dates: 14. Race - American Indian, 11, Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: ģ XXXWidowed 4 Divorced "neturel", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiens. Importent: If item 27 is marked other then "ne eny injury or other treumatic event, Itte Macle once. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Minnie Matthews Francis Reagan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma M. Schlorb - Daughter 4112 25th Avenue Temple Hills, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MX Burial 2 Cremation 3 Removal from State Cedar Hill Cemetery May 14, 2008 Suitland, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature Juneral Septoe License 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part of the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Privsician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto for as a consequence of Examiner burial-transit and Due to (or as a consequence of): attending physician Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð Dementia 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2XX No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 0 1XXYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: After 5 Pending investigation 1 Watural 1 Yes 2 No death. 2 Accident after death 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

Hospital or Attending Physicien: 24 hours a the To the

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

death with the Maryland

filed within 72 hours after

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

29a. Certifier

29b. Signature and title of ca

Christian LeFevre 2112 F. Street N.W. 32. Re

and manner stated

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

#603

10731

29d. Date signed (Month, Day, Year)

20037

05/09/2008

Washington, D.C.

| Marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at to recognize the completed by Euroral Director   | n<br>Il<br>r | State Registrar  1. Decedent's Name (First, Middle, Last)  Zelda Eloise Simpkins  4a. Facility Name (If not institution, give street and number)  Caroline Home for Hospice |                        | tificate of E                             | Jeath<br>            | 2. Date of D                   |                |                              | 3. Time of                       | Death      |
|--|--------------|---|------------------------|---|----------------------|--------------------------------|----------------|------------------------------|----------------------------------|------------|
| /Medical<br>Examiner<br>Funeral<br>Director  | n<br>Il<br>r | Zelda Eloise Simpkins 4a. Facility Name (If not institution, give street and number)  |                        |   |                      |                                |                | 3.6                          | 0. 11110 0                       | DOMI       |
| Examiner Funeral Director  | r            | 4a. Facility Name (If not institution, give street and number)  |                        |   |                      |                                | Day            |                              |                                  | , M        |
| Funeral<br>Director  |              |   |                        | 4b. City, Town, or                        | Location of De       | May                            | 15             | 2008<br>County of Dea        | 2:00                             | A          |
| Director   |              |   |                        | -   |                      | aur                            |                |                              |                                  |            |
| Director   |              | 5. Social Security Number 6. Sex 7. Age (In yrs. las  | st birthday)           | Dent                                      | CON<br>If Under 24 H | rs. 8. Date of B               | Birth          | Caroli:                      | thplace (State                   | or Foreigi |
|  | - 1          | 224-50-0353 1 M 2 F 78  | Yrs.                   | Months Days                               | Hours Mi             |                                | Day, Year)     | C                            | ountry)                          | Ü          |
| tems 23a or 28a-f show er must be notifled at notifled at notal Director   |              | Usual Residence of Decedent   |                        |   |                      | August                         | 10, 19         | 129 UI                       | nio                              |            |
| er must be notified  |              | 10a. State 10b. County 10c. City,   | Town or Loc            | ation                                     | -                    |                                |                |                              | 10d. Inside C                    |            |
| er must be not   |              | Maryland Talbot Tra   | appe                   |   |                      |                                |                |                              | 1 □ Yes                          | 2 N        |
| er must be   | ě            | 10e. Street and Number  | 70                     | 10f. Zip Code                             |                      |                                | 10g. Cit       | izen of What Co              | ountry?                          |            |
| er mu  |              | 5025 Marsh Road   |                        | 21673                                     |                      |                                | <br>  nite     | ed State                     | s of Ame                         | aric       |
| 9 0  | ler.         | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?  | . 13. W                | /as Decedent of His<br>Yes, specify Cubar | spanic Origin?       | (Specify Yes or N              |                | 14. Race - Ame<br>Black, Whi | erican Indian,                   |            |
| 등 등 교  |              | 1 Never Married 2 Married 1 Yes 2 1 No  |                        | Yes 2 No                                  |                      | eno mican, etc.)               |                |                              | ,                                |            |
| Exan   | 2            | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:  | '                      | ∐ Yes ∠LAN140                             | Specify:             |                                |                | Specify: Car                 | ucasian                          |            |
| ygiene.<br>ner than "natura<br>nt, the Medical E   | e led        | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Decede            | ent's Usual Occupa                        | ition                | vorkina                        | 16b. K         | ind of Business              | /Industry                        |            |
| an "I  | <u> </u>     | Elementary/Secondary (0-12) College (1-4or 5+)  | life. D                | kind of work done d<br>O NOT use retired) | )                    | · cining                       |                |                              |                                  |            |
| the th   | 5            | 10  | Green                  | <u>house wor</u>                          |                      |                                |                | florist,                     | /Garden                          | <u>P1a</u> |
| d other<br>event, the  | e l          | 17. Father's Name (First, Middle, Last)   |                        |   | 18. Mother's N       | lame (First, Midd              | le, Maiden     | Surname)                     |                                  |            |
| Mental arked o atic eve  | 0            | Emmett Ray Halfhill   |                        |   | Effie                | Viola                          | Davis          | 5                            |                                  |            |
| s ma   |              | 19a. Informant's Name/Relationship (Type. Print)  | 19b. Mailing           | g Address (Street a                       | and Number or        | Rural Route Nurr               | nber, City o   | or Town, State,              | Zip Code)                        |            |
| nt of Health and Ment<br>t: If Item 27 Is marked<br>f or other traumatic e   |              | Debra Lehmann Daughter  | 28229                  | Greenwoo                                  | d Road               | , Denton                       | , Mai          | cyland                       | 21629                            |            |
| a fe fe  |              | 20a. Method of Disposition 20b. Pla   | ace of Dispos          | sition (Name of<br>natory or other place  | e)                   | Date                           | 20c. Lo        | ocation - City or            | Town, State                      |            |
| 7 ent  |              | 1 Buriai 2 Cremation 3 Removal from State   |                        | 11 Cemete                                 |                      | 110100                         | T              | M.                           | 1                                |            |
| Department of Important: If It any Injury or one.  | 1            | 21. Signature of Funeral Service Licensee   | 22.                    | Name and Address                          | s of Facility        | /19/08                         | 1 ITE          | appe, Ma                     | aryland                          |            |
| any p  |              | Hay orlay a none  | l M                    | oore Fune                                 | eral Ho              | me, P.A.                       | Dont           | M.                           | -1 1 0                           | 1620       |
|  | -            | 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.   | Do not ente            | 2 South S                                 | econd (              | Street,<br>liac or respiratory | arrest,        | on, Mary                     | Approxima                        | te         |
|  |              | shock, or heart failure. List only one cause on each line.  Immediate Cause (Final  |                        | 100                                       | - A                  |                                |                |                              | Interval Be<br>Onset and         | Death      |
| iysician<br>Medical  |              | disease or condition resulting in death)  | C                      | ance                                      |                      |                                |                |                              | MOUT                             | hs         |
| aminer   |              | Due to (or as a co were   | ence of):              |   |                      |                                |                |                              |                                  |            |
| i Me   | _            | Sequentially list conditions, if any, leading to immediate b.  Due to (or as a conseque   | ence of):              |   |                      |                                |                |                              | -                                |            |
| nsit   |              | cause. Enter Underlying Cause (Disease or injury  |                        |   |                      |                                |                |                              |                                  |            |
| in and ial-transit   | xar          | that initiated events c   | ence of):              |   |                      |                                |                |                              |                                  |            |
| physician and<br>s the burial-transit  |              | ,   | ,                      |   |                      |                                |                |                              |                                  |            |
| physicia<br>the bur  | aic          | d   |                        |   |                      |                                |                |                              | -                                |            |
| d by the attending prefetached for use as  | Me           | IF FEMALE: 23c. If yes, outcome pf pregnance  | 101                    |   |                      |                                |                | 001.0                        |                                  |            |
| or us  | au           | in the past 12 months?  | death 3□               | Ectopic pregnancy                         |                      |                                |                | 23d. Date of de<br>Month     | ,                                | Year       |
| by the a   | SIC          | 1 ☐ Yes 2 No 4 ☐ Pregnant at time of dea<br>9 ☐ Unknown 9 ☐ Unknown   | ath 5∐                 | Other (specify)                           |                      |                                | -              |                              |                                  |            |
| d by   | Ē            | Part II. Other significant conditions contributing to death but not result  | tion in the un         | darlying causa give                       | n in Part I          | 23a Die                        | t tobacco      | use contribute t             | o the cause of                   | death?     |
| be o   | 2            | Part II. Other significant conditions continuoung to death but not result   | ang in the an          | denying cause give                        | arm raiti.           |                                |                | □ No 3□F                     |                                  | Onkno      |
| cate has been significantly to page 2 should to completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the completed to the complete to th | lea          |   |                        |   |                      | -   '-                         | J 163 Z        | 140 3                        | TODADIY 4                        | OTIKTIO    |
| as be  | ble          |   |                        |   |                      | 24a. Wa                        | as an<br>topsy | 24b. Were a                  | utopsy findings<br>completion of | availat    |
| certificate has birector, page 2 s   | é            |   |                        |   |                      | pe<br>1□ Yes                   | rformed?       | death?                       | s 2□No                           |            |
| this certificated director, I  |              | 25. Was case referred to medical  |                        |   | 26. Place of D       | Death (Check only              | y one)         |                              |                                  |            |
| this ce  |              | examiner? 1 Yes 2 Hospital: 1 Inpatient 2 E   | R/Outpatient           | 3 DOA Othe                                | er:<br>4 🗆 Nursing   | g Home 5 □ Re                  | sidence        | 6 Other (Sp.                 | ecify hos I                      | Sic        |
| After th funeral   |              |   | 28b. Time of<br>Injury | 28c. Injury<br>Work                       | at                   | 28d. Describ                   | e how inju     | ry occurred                  |                                  |            |
| e for  | 2110         | 1 Natural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  | ,a.ry                  |   | ves 2 □ No           |                                |                |                              |                                  |            |
| after death Director: J in by the f  | Ë            | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At hom building, etc. (Specify)   | ne, farm, stre         | eet, factory, office                      |                      | 28f. Location                  | (Street all    | nd Number or F               | Rural Route Nur                  | nber,      |
| rs after death. al Director: After led in by the funer.  | E            | building, etc. (opcomy)   | ·                      |   |                      | ony or ,                       | om, otat       | <i>-</i> /                   |                                  |            |
| nnera<br>y fille   |              | 29a. Certifier 1 Certifying Physician: To the best of my know   |                        |   |                      |                                |                |                              |                                  |            |
| he Fune<br>pletely fi  |              | (Check only one)  2 Medical Examiner: On the basis of examination and manner stated.  | on and/or inv          | estigation, in my op                      | pinion, death o      | ccurred at the tim             | ie, date an    | id place, and du             | ie to the cause                  | s)         |
| within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director, I Madical Certification: To Be C  | Me           | 29b. Signature and title of certifier   |                        | 29c. License                              | number               |                                | 29d. Da        | ate signed (Mor              | nth, Day, Year)                  |            |
| >   0  |              | 1 James X 62.   | اد دسه                 | 72  | 12                   | 70                             | 5              | -15                          | -08                              |            |
|  | 1            | 100 Name and a filesce of course who appealed a supplied files.   | 230) (Time 1           | Print)                                    | 11/1                 | 6                              |                |                              | _ ()                             |            |
|  |              | 30. Name and address of person who completed cause of death (Item 2   |                        |   | M 1                  | 1 014                          | 20             |                              |                                  |            |
|  | e            | James Sides, M.D., 920 Market S 31. Date filed (Month, Day, Year) 32 Registrar's Signature  | treet                  | , penton,                                 | Maryla               | and 216:                       | 29             |                              |                                  |            |

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician 2008 1:30 A May Howard Bradford Strannahan /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Dorchester 3926 Willey Road Hurlock If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country) Maryland Sex tX M 2□F 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Social Security Number **Funeral** Months 79 Nov. 1928 1 213-22-8588 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 1 ☐ Yes 2 No Talbot St. Michaels Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21663 U.S.A. 914 Riverview Terrace Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. ģ 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chemical Comp Elementary/Secondary (0-12) 12 College (1-4or 5+) Federal Paper and owner/operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Enoch Strannahan Margaret Willoughby Strannahan 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3926 Willey Road; Hurlock, Maryland Jacque Schnitzer/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 Removal from State Greensboro Cemetery | 05/17/2008 | Greensboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears patic /Medical Due to ( r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 ☐ Could not be n 24 hours after des ne Funeral Directo pletely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

ar's Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

00

**ORIGINAL** 

Teal Dr. Suite 204 Easton, MD 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, 'Middle, Last) 2. Date of Death **Physician** 14360 M **EUGENE** RICHARD SHANHOLTZ 05  $\infty$ /Medical 4c. County of Deat 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY COMBERLAND MEMORIAL HOSPITAL Birthplace (State or Foreign Country) Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Date of Birth (Month, Day, Year) **Funeral** Days Hours 215-28-8780 1**X** M 2 □ F Yrs. Director 76 14,1932 WEST VIRGINIA Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location a or 28a-f show be notified at 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No Director WV MINERAL FORT ASHBY 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Hygiene. other than "natural", or items 23a or rent, the Monical Examiner must b BRIDGE ROAD 26719 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ☐ Widowed 4 Divorced WHITE Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION DRIVER 10 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ies 1 and 2 should be fill of Health and Mental H Be SHANHOLTZ LOU BENDER ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYDIA JEAN HAWKINS / EXECUTRIX FORT ASHBY, WV P.O. BOX 341, 26719 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 Burial 2 □ Cremation 3 □ Removal from State LEVELS CEMETERY 05/10/2008 4 ☐ Donation 5 ☐ Other (Specify) LEVELS, WV 21. Signature of Funeral Service License UPCHURCH FUNERAL HOME, INC. 26719 P.O. BOX 1260, FORT ASHBY, Approximate Interval Between Onset and Death 23a. Part1. Enter the deease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician INTRACRANIAL HEMORRHAGE /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any translation in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine death certificate be executed and Due to (or as a consequence of) signed by the attending physician a d be detached for use as the burial-Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. I ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy perform certificate funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 28a. Date of Injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) Injury within 24 hours after death.

To the Funeral Director: At completely filled in North М 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier **Example 1** X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0066670 8 30. Name and address no completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

MAY 1

3 2008

MRS

DHMH 17 Rev 1/2001

32. Relistrar's Signature

900 seton De. Cumberland, MD 21502

|             |  |                  | For<br>State<br>Registrar  | State of M  |   | partment of F<br><i>ertificate of</i>  |  |  | ene 2008  | 3 17111  |
|-------------|--|------------------|--|---|---|--|--|--|---|--|
|             | Physici<br>/Medic  | _                | Decedent's Name (First, Middle Girlie Mae Schart   |   |   |  |  | 2. Date of Death<br>Month<br>May 7, 20           | Day Year  | 3. Time of Death 2:10 p M                                  |
|             | Examin Funeral Director  | er               | 4a. Facility Name (If not institution  Magnolia Center  5. Social Security Number  579–03–8935   | 6. Sex 7. Ag  | ge ( <i>In yr</i> s. las <i>t birthd</i> a<br><b>97</b> Yrs   | Lanham  If Under 1 Year  Months Days   | If Under 24 Hrs. Hours Min.                                | 8. Date of Birth<br>(Month, Day,<br>April 30,    | 4c. County of Dea  Prince Ge  9. Bir Co 1911 Virg |  |
| Be          | 70   |                  | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or  | Location   |  |  |   | 10d. Inside City Limits                                    |
|             | a-f sho  | ctor             | Maryland Prince  | e George's  | Hy  | attsville/   |  |  |   | 1 ☐ Yes 2 🖾 No   |
|             | h with the   | al Director      | 10e. Street and Number 4865 66th Avenue  |   |   | 10f. Zip Code<br>20784   |  | 10   | g. Citizen of What Co<br>USA                      | ountry?  |
| 5-0036      | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>fical Examiner must be notified at   | by Funeral       | 11. Marital Status  1 □ Never Married 2 □ Marri  \$€  Widowed 4 □ Divorced   | 12. Was Decedent Armed Forces? ied 1 Yes 2 If Yes, Give Year or Dates:    | Ever in U.S. 1  | 3. Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2 🛣 No  | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify:    | ecify Yes or No-<br>Rican, etc.)                 | 14. Race - Ame<br>Black, Whit<br>Specify: Whi     | te, etc.   |
| 0-612       | vithin 72 ho<br>ne.<br>han "natur<br>e Medical I   | Completed        | 15. Decedent<br>(Specify only highest<br>Elementary/Secondary (0-12)   | t's Education<br>st grade completed)  College (1-4or                      | (G  | cedent's Usual Occup<br>ive kind of work done<br>e. DO NOT use retire  | during most of work<br>d)                                  | sing 1   | 6b. Kind of Business                              |  |
| 70          | filed w<br>Hygier<br>Ither the   |                  | 12 17. Father's Name ( <i>First, Middle,</i>   | Last)   |   | Beautio  | <del></del>  | e (First, Middle, M                              |   | Styling  |
| land        | Jid be<br>Jental<br>rked o<br>tic eve  | To Be            | Harry Garrett  | ,   |   |  | Neva Dav   | is   |   |  |
| Mary        | nd 2 shou<br>lith and M<br>27 Is mar<br>r traumat  |                  | 19a. Informant's Name/Relations<br>Manley S. Sull  | hip <i>(Type. Print)</i><br>Livan/Personal                                | l l   | ailing Address (Street<br>6711 Kimb  |  |  | City or Town, State,                              | * *  |
| Baitimore,  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | -                | 20a. Method of Disposition  1 ☐ Surial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S  | pecify  | cemetery, o   | sposition (Name of crematory or other placemorial Park 22 Name and Address of the control of the | ess of Facility  | May 13,<br>2008 (                                | hester, Vin                                       | pinia  |
| 1           | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)                            | complications that cause only one cause on each I  Acut  a. Due to (or as | d the death. Do not ine.  ce Respirator  s a consequence of): | enter the mode of dyi  |  | •  |   | Approximate Interval Between Onset and Death  1 day  years |
| 0876U,      | eath certificate be executed attending physician and for use as the burial-transit   | edical Examiner  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | b. — Due to (or as  | b. Tue to (or as a consequence of):  c                        |  |  |  |   |  |
| O. Box 62   | attending<br>for use a   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |   | 2 Fetal death   | 3 □Ectopic pregnanc<br>5 □ Other (specify) _   | у  |  | 23d. Date of de<br>Month                          | l<br>blivery<br>Day Year                                   |
| cords, P.   | w requires that the de<br>been signed by the<br>should be detached   | þ                | Part II. Other significant condition Paroxysmal Atrial I   |   | but not resulting in th                                       | e underlying cause gi  | ven in Part I.   |  |   | o the cause of death?  Probably 4 Unknown                  |
| Ital Heco   | The lay<br>ate has<br>page 2   | Completed        |  |   |   |  |  |  | y prior to<br>ned? death?<br>E⊠ No 1 □ Ye         |  |
| >           | Physician:<br>r this certific<br>ral director,   | To Be            | 25. Was case referred to medica examiner? 1 ☐ Yes 2 ☑ No   | Hoenital:   | ient 2 ☐ ER/Outpa   | tient 3 DOA Ot   | her.   | th <i>(Check only one</i><br>ome 5 ☐ Reside      | nce 6 □Other (Sp                                  | ecify)   |
| DIVISION OF | or Attending<br>fter death.<br>Director: After<br>in by the fune   | Certification: T | 27. Manner of Death  **XX** Natural 5 Pendin 2 Accident investig 3 Suicide 4 Homicide 6 Could determ   | gation not be 28e. Place of in  | ay Year) Inju   | ry Wo  | ]Yes 2□No  | 28d. Describe ho 28f. Location (Str City or Town | eet and Number or F                               | Rural Route Number,  |
| _           | plts<br>purs<br>pers<br>fille  | Medical Ce       |  | ng Physician: To the best<br>Examiner: On the basis<br>and manner s       | of examination and/o  |  |  |  |   |  |
| )           | To the Hos within 24 hd To the Fun completely  | Med              | 29b. Signature and title of certifie   | len   |   |  | 29c. License number 29d. Date signed (Month, D May 9, 2008 |  |   |  |
|             |  |                  | 30. Name and address of person Peter M. Schissler  | r, MD 7500 G  | Greenway Cen  | ter Drive, G   | reenbelt, M  | D 20770  |   |  |
| ľ           | Sta<br>Regist  |                  | 31. Date filed (Mor A), Yar)   | 2 2008 32. Sgist  | trar's Signature  | Gerti  |  |  |   |  |

Division or Vital Records, P.O. Box 68760,

State Registrar 31. Date filed (Month, Pay, Year) 2 2008

29b. Signature and title



29c. License number

D24093

29d. Date signed (Month, Day, Year)

May 6, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Year **Physician** 2:12 a M Abigale Sewitch 07 2008 Mav /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Suburban Hospital Montgomery Bethesda If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X F 81 Director 054-20-4684 July 22, 1926 New York Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Wedical Examinar in ust be notified at 1 ☐ Yes 2 🔼 No Director Rockville Maryland Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20852 U.S.A. 6111 Montrose Avenue, #803 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 □Yes 2 ☑ No If Yes, Give Year or Dates; 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify. \$ Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Benjamin Katz Tessie Berstein ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Hyams - Son 6416 Utah Avenue, NW, Washington, D.C. 20015 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 X Removal from State 05/08/2008 Pinelawn, L.I., N.Y. Wellwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Survive Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E for Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tran Due to (or as a consequence of): attending physician for use as the buria 513 Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months' 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Q 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2 🗆 No 2 100 1 □Yes 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 ☐ Yes 2 **N**0 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☑ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred ospital or Attending I hours after death. 5 | Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident the 1 To the Funeral Director: 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 24

Division of Vital Records,

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State Registrar 31. Date filed (Month Pay 12 2008

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature

vone

8600 Old Georgetown Road

29d. Date signed (Month, Day, Year)

29c. License number

Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:25 PM 2008 May 8 Muriel W. Schaffer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery 1909 Narrows Lane Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Days Hours 1 □ M 2 🖾 F Yrs. New York 80 June 27, 1927 216-22-2321 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1KIYes 2□No Director Silver Spring MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 20906 1909 Narrows Lane Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Baltimore, Maryland 21215-0036 Specify: Specify: Completed by White 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking 12 Proof Training 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tillie Baron Michael Wolk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Silver Spring, MD 20906 Candice Segal - Daughter 1909 Narrows Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 5/9/2008 Olney, Maryland Judean Mem. Gardens 21. Signature of Funeral Service License 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Rockville, MD 20852 1091 Rockville Pike 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 34 months Physician Endometrial Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) attending physician for use as the burial Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕱 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Alzheimers 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1∐ Yes certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No 1 Inpatient Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide To the Hospira. S. within 24 hours after de To the Funeral Direction of To the Funeral Direction by determined 4 Homicide 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b Signature and tipe of certifier

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

 $\mathbf{M}$ D

32. Rastrar's Signature

Aylesworth,

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A.

31. Date filed (Month, Pay, Year)

Chery1

D54378

2730 University Blvd. W. #400 Wheaton, MD 20902

| Oscar Manue<br>08-03492   | iL            | cpc3 Sanche2<br>Please Type or Print in Black Indelible Ink. Ensure All Cop  | oies Are Leg              | ible.   |            |
|---|---------------|--|---------------------------|---|------------|
| UNK UNK   |               | State of Maryland / Department of Health and Mental  1- For State Certificate of Death  Registrar  |                           | 2008 171  | The second |
| Physicia<br>Medical Exami   | an/           | Decedent's Name (First, Middle,Last)     Oscar Manuel Lopez Sanchez  | 2. Date of Death<br>Month | Day Year 4400 has   |            |
| Medical Exami   | ner           | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of De  | May 7, 200                | 4c. County of Death   | -          |
| `   |               | Rt. 140 and Nob Hill Park Drive Glyndon  |                           | Baltimore County  |            |
| Funeral<br>Director   |               | 703-00-0031 1 X <sub>M</sub> 2 F 34 Yrs.   | 1.0                       | 9, 1974 Mexico  | reign      |
| ınd<br>show any<br><u>ace.</u>  | 7             | Usual Residence of Decedent  10a. State  |                           | 10d. Inside City Lin 1 X Yes 2  |            |
| h the Maryla<br>3a or 28a-f   | l Director    | 10e. Street and Number 3141 Hillcrest Avenue 21074   |                           | g. Citizen of What Country? Mexico                                      |            |
| Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 13a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | Funeral       | 11. Marital Status 1 Never Married 2 X Married    12. Was Decedent Ever in U.S.    13. Was Decedent of Hispanic Origin?    14. Yes 2 X No    15. Was Decedent of Hispanic Origin?    16. Yes 2 X No    17. Yes 2 X No    18. Yes 2 X No    19. Yes 2 X | erto Rican, etc.)         | 14. Race - American Indian, Black, White, etc.  Specify: White          |            |
| hours aff<br>natural'<br>Examine  | ed by         | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind during most of working life, DO NOT use   |                           | 16b. Kind of Business/Industry  |            |
| 036<br>ithin 72<br>ne.<br>r than "<br>Tedical   | Completed     | Elementary/Secondary (0-12) College (1-4 or 5+)  Secondary (0-12) College (1-4 or 5+)  Landscapping  |                           | Landscape   |            |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | Be Co         |  | ame (First, Middle, M     | aiden Surname) Angeles Sanchez  |            |
| 212<br>thould be<br>and Ment<br>is mark   | 임             | 19a. Informant's Name/Relationship (Type, Print) roller/19b. Mailing Address (Street and Number Victor Alfonso Lopez Sanchez 3141 Hillcrest  | or Rural Route Num        | ber, City or Town, State, Zip Code)                                     |            |
| e, MD<br>1 and 2 sho<br>Health and<br>item 27 is  |               | 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,  | Date                      | 20cy Location - City or Jown State an                                   | -          |
| Baltimore,<br>permit. Pages 1 an<br>Department of Her<br>Important: If ite  | l             | 1 Nonglion 5 Other Special Calpaneria Atexquiliar  | 417/2008                  | Puebla, Mexico  |            |
| Balt<br>permit<br>Depart<br>Impor   |               | 21. Signal to Funeral Service Consee PATTLIP DERINAL 9241 Columbia   | DI FUNEI                  | RAL SERVICE, P. A.<br>Lver Spring, Md209                                | 910        |
| Physician<br>/Medical   |               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardifailure. List only one cause on each line.  |                           |   | erval      |
| xaminer   |               | Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of):  |                           | Beauty  | -          |
|   | Jer           | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):   |                           |   | $\dashv$   |
| _ =   | xaminer       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  |                           |   | -          |
| executed<br>an and<br>al - trans  | calE          | d. UNPENDED AMENDED  |                           |   |            |
| 68760, certificate be rading physicis se as the burits  | ian/Medical   | IF FEMALE: 23c. If yes, outcome of pregnancy   |                           | 23d. Date of delivery   |            |
| Box 68760, re death certificate be execute the attending physician and red for use as the burial - tran   | sician        | 23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pr 4 Pregnant at time of death 5 Other (Specify)   | egnancy                   | Month Day Year  |            |
| ). Box<br>the death c<br>by the atten<br>ched for us  | Phys          | 1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did to               | bacco use contribute to the cause of death                              | 1?         |
| res that the signed by the detac  | þ             |  |                           | 2 No 3 Probably 4 Unknown   |            |
| of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach  | ompleted      |  | 24a. Was a autop:         | sy prior to completion of cause   |            |
| Vital Rec<br>ysician: The I<br>his certificate h  | ပ             | 25. Was case referred to medical 26. Place of Death (Ch  | 1 ✓ Yes                   |   | lo         |
| Vital tysician this cert  | o Be          | examiner?  |                           | Residence 6 Other: Scene  |            |
| in of adding Ph. h. therefore a funeral   | on: T         | 27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury FOUND:  28b. Time of Injury 28c. Injury at Work? FOUND:  1 V Yes 2 No.   | Filected nas              | ow injury occurred<br>senger auto collision                             |            |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the Function: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri                         | ertification: | 2 Accident Investigation May 7, 2008 11111 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc.  | 28f. Location (S          | Street and Number or Rural Route Number, tate)                          | , City     |
| Hospital<br>24 hours<br>Funeral   | ပ             | 4 Homicide determined (Specify) Major Road / Highway  29a. Certifier (Check only) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,   | -                         | Hill Park Dr, Reisterstown, MD e(s) and manner as stated.               |            |
| To the within To the comple   | Medical       | one)  2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occur and manner stated.   | red at the time, date a   | and place, and due to the cause(s)  29d. Date signed (Month, Day, Year) |            |
|   | 2             | 29b. Signature and title of certifier  O.C.M.E.  |                           | May 8, 2008   |            |
|   | - V4          | 30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21   | 1201                      |   |            |
|   | ate           | 31. Date filed (Month, Cax Year) 2 2008 32. Red strar's Signature  |                           |   |            |
| Regis   | trar          | WILL IT OF FOOD TO THE PARTY OF |                           |   |            |

Registrar

Dorg 10/11/25 Dord

55#218-18-549

Street, Cuften

32. Registrar's Signature

3 2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 05 ÕŜ 2008 SMITH 1828 KATHLEEN LOUISE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ALLEGANY WMHS - BRADDOCK CAMPUS CUMBERLAND If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗓 F 68 214-36-6425 Director 06/01/1939 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r 28a-f show notified at 1 TyYes 2 □ No MD Director Allegany Cumberland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number a or 810 Sylvan Avenue 21502 USA "natural", or items 23a Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hyglene. ant; If item Z7 Is marked other than "natural", or items 23s ant; If item 27s marked overlier than "natural", or other traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 2 3 X Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Helen August Rosley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leonard J. Smith / Son 815 Deep Lake Drive, Cranberry 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. Cumberland Crematory 05/05/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, F.A. 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 23a. Part1. Errer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) CONCESTIVE **Physician** (HEARS /Medical Due to (or as a consequence of): Examiner CARS UMMORA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine CORUN ARY sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 M No 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bade 2 s autopsy performe certificate 2 No 1☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 (Month, Day Year) 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, I Director: d in by the within 24 hours aft

To the Funeral Di

completely filled in

> MAS State Registrar

3

DHMH 17 Rev 1/200

Medical

31. Date filed

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of certifier

determined

Halm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

\$ 2690

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 21, 2008 E. Talley 3:23am Jane 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 41 New Hampshire Avenue Cumberland Allegany 8. Date of Birth (Month, Day, ) Sep 10, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1942 1 M 2 F 214-42-0778 MD 65 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Allegany MD Cumberland 1 Ves 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 41 New Hampshire Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) nurses aide Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William A. Lange C. Elizabeth Furstenberg Wilson 19a. Informant's Name/Relationship (Type. Print) David Talley Majling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 New Hampshire Cumberland MD 21502 husband 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 5/23/2008 MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funera S 22. Name Scarber Puneral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1 Enter the disease shock, or heart failure. Immediale Cause (Final disease or condition resulting in death) Due to (or as a consequence of)

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

**Funeral** 

**Director** 

r 28a-f show notified at

items 23a or iner must be n

the Medical

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Many injury or other traumatic event, the Mones.

Funeral Director

Completed by

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

within 24 hours after death

To the Funeral Director:
completely filled in by the f

Division or Vital Records, P.O. Box 68760, 😴

To the Hospital or Attending Physician: The law requires that the death certificate be executed

| dical Examiner    | b. Due to (or as a consequence of):  ause. Enter Underlying Cause (Disease or Injury hat initiated events esulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d |   |   |  |  |  |  |  |  |  |
|-------------------|--|---|---|--|--|--|--|--|--|--|
| Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 23c. If yes, outcome pf pregnancy  1  | 23d. Date of delivery<br>Month Day Year   |  |  |  |  |  |  |  |
| Completed by Pr   | Part II. Other significant conditions of   | ontributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?  1   |  |  |  |  |  |  |  |
| Be                | 25. Was case referred to medical   |   | n (Check only one)  |  |  |  |  |  |  |  |
| 0                 | examiner?<br>1 ☐ Yes 2 ☐ No  | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA Other: 4   Nursing Ho   | me 5♣ Residence 6 □Other (Specify)  |  |  |  |  |  |  |  |
| Certification: T  | 27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined  | 28a. Date of Injury (Month, Day Year)  28b. Time of Injury M  28c. Injury at Work? 1 □ Yes 2 □ No  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) | 28d. Describe how injury occurred  28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |  |  |  |
| ca                |  | ysician: To the best of my knowledge, death occurred at the time, date and place,<br>niner: On the basis of examination and/or investigation, in my opinion, death occurr                 |   |  |  |  |  |  |  |  |

29c. License number

D0033280

AVE. ("UMBERLAND, MO

29d, Date signed (Month, Dav. Year)

State Registrar 29b. Signature and title of certified

624 2. Registrar's Signature

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year 9:55/M Physician 2008 may Thomas Hiawatha /Medical James 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctor's Community Hospital Lanham 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number Days Min 1**X** M 2□ F Months Yrs. Dec 12. North Carolina 80 243-32-5774 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County TY□Yes 2 □ No Bladensburg Maryland Prince George's Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20710 5427 Spring Road Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. African 1 □ Never Married 2 Married 1 ☐ Yes 2√∑ No ð 3 ☐ Widowed 4 ☐ Divorced American Year or Dates Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Engineer Private vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Correll James F. Thomas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5427 Spring Road Bladensburg, MD 20710 Dorothy Jean Thomas - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ▼Bunal 2 □Cremation 3 □Removal from State 4 □Donation 5 □ Other (Specify) Lincoln Cemetery | May 16, 2008 Brentwood, MD Ft. 22. Name and Address of Facility Stewart Funeral Home, Inc. 21. Signature of Funeral Serv 4001 Benning Road, NE Washington, DC 20019 23a. Parkt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colon Cancer resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Vear in the past 12 months? 4☐Pregnant at time of death ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed: 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident

law requires that the death certificate be executed and burial-tran Division or Vital Records, P.O. Box 68760, physician as attending use for detached page 2 s has certificate director, this Hospital or Attending within 24 hours after death

To the Funeral Director:
completely filled in by the

**Funeral** 

Director

"natural", or items 23a or 28a-f show dical Examiner must be notified at

with the Maryland

death

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other i any injury or other traumatic event, t<u>it</u>

**Physician** 

/Medical

Examiner

28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) MOSTAGHIM

20770 GREENBELT MD 7305 HANDVEL PARKUAY

State Registrar

Medical

31. Date filed (Month, Day, Year) MAY 1 3 2008

32. Registrar's Signature

11.0.

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|  | For  | artment of Health and I  | Mental Hygiene   |
|--|--|--|--|
|  |  | rtificate of Death   | Reg. No. 2 1 1 8 7 2   |
| Physician<br>/Medical  | 1. Decedent's Name <i>(First, Middle, Last)</i> Carol Jean Thomas  |  | 2. Date of Death Month Day Year 0628 M   |
| Examiner   | 4a. Facility Name (If not institution, give street and number) PININSULA REQUINAL MEDICAL CONFU  | 4b. City, Town, or Location of Death   | Wicamico   |
| Funeral<br>Director  | 5. Social Security Number 6. Sex 1. Age (In yrs. last birthday 1.  | Months Days Hours Min.   | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) APril 24 1947 Maryland            |
| Maryland a-f show iffed at   | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Maryland Caroline Denton   | ocation  | 10d. Inside City Limit   |
| with the   | 10e. Street and Number 304 Caroline Apartments   | 10f. Zip Code 21629  | 10g. Citizen of What Country? USA  |
| ins after death with the Mar<br>il", or items 23a or 28a-f sl<br>examiner must be notified<br>by Funeral Director  | 11. Marital Status  1 \( \mathbb{N} \) Never Married 2 \( \mathbb{M} \) Married If Yes 2 \( \mathbb{N} \) No If Yes 2 \( \mathbb{N} \) No If Yes, Give   | Was Decedent of Hispanic Origin? (S<br>If Yes, specify Cuban, Mexican, Puerto<br>1 □ Yes 2 No Specify: | pecify Yes or No-<br>o Rican, etc.)  14. Race - American Indian,<br>Black, White, etc.  Specify: White         |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any njury or other traumatic event, the Medical Exemples must be notified at once.  To Be Completed by Funeral Director                                    | 15. Decedent's Education (Specify only highest grade completed)  [Sementary/Secondary (0-12)   College (1-4or 5+)  | edent's Usual Occupation e kind of work done during most of work DO NOT use retired)                   |  |
| i be filed wantal Hygier ed other the event, the   | 17. Father's Name (First, Middle, Last)  James W. Thomas   |  | own home ne (First, Middle, Maiden Surname) Kae Reedy Ratliff  |
| 2 should and Mer is marke aumatic  | 19a. Informant's Name/Relationship (Type. Print) 19b. Maii   | ing Address (Street and Number or Ru   | ıral Route Number, City or Town, State, Zip Code)  |
| ges 1 and 3<br>nt of Health<br>if item 27<br>or other tr   | 20a. Method of Disposition  20b. Place of Disposition  1 XBurial 2 Cremation 3 Removal from State  | osition (Name of ematory or other place)   | Date 20c. Location - City or Town, State   |
| permit. Pa<br>Departmer<br>Important:<br>any injury<br>once.   | - Laboration of Leaner (openity)   | 22 Name and Address of English   | Denton, Maryland bein Funeral Home, PA   |
| Physician<br>/Medical  | 23a. Part 1. Enter the disease, or complications that caused the death. Do not explored the disease, or complications that caused the death. Do not explored the disease or condition at the disease o |  |  |
| icate be executed by physician and the burial-transit to dical Examiner  | Due to (or as a consequence of):  Secure thatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  | Myo fasciitis  |  |
| Io the hospital of Attending Physician: The law requires that the death certification 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as a managed by the funeral director. The Becampleted by Physician/Medical Certification: To Be Completed by Physician/Medical Certification: |  | ☐ Ectopic pregnancy ☐ Other (specify)  | 23d. Date of delivery  Month Day Year  |
| quires that n signed build be deta   | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  1  |
| n: The law requir ficate has been s r, page 2 should Completed   |  |  | 24a. Was an autopsy performed?  1 Yes 2 No 1 Yes 2 No  |
| hysician<br>this certifial director  | 25. Was case referred to medical examiner?  1  Yes   | Other  | ath (Check only one)  Home 5 Residence 6 Other (Specify)   |
| ath. r: After the funeral  | 27. Manner of Death  1 Natural 2 Accident  28a. Date of Injury (Month, Day, Year)  28b. Time Injury  | of 28c. Injury at Work?  M 1 □ Yes 2 □ No  | 28d. Describe how injury occurred  |
| To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.  Medical Certification: To Be C.  | 3 ☐ Sulcide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                                |
| the Hospi<br>ithin 24 hou<br>the Funer<br>ompletely fill   | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deadle in the properties of the prop | ath occurred at the time, date and plac<br>investigation, in my opinion, death occi                    | e, and due to the cause(s) and manner as stated.<br>urred at the time, date and place, and due to the cause(s) |
| To th withir To th comp  | 29b. Signature and title of certifier  MMM  MO   | 29c. License number  | 29d. Date signed (Month, Day, Year)  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type   | 9, Print)  | MONT AVENUE STIETE   |
| State<br>Registrar   | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | 1300   | LMONT AVENUE, SUFTE<br>SALISBURY, MD   |

DHMH 17 Rev 1/2001

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### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 MAY 10:36AM MARGARET C. TILDEN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) TALBOT EASTON WILLIAM HILL MANOR 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) Months Days Hours NEW YORK 1 M 2 X Yrs JUN 6, 103 1904 076-22-0167 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 X Yes 2 □ No EASTON MD TALBOT 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21601 USA 501 DUTCHMANS LANE 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify 3 XWidowed 4 ☐ Divorced WHITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) BOOKKEEPER RETAIL 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) MARY VERONICA GROGAN JAMES MAGEE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 278 ELM ST., WEST HEMPSTEAD, NY 11552 JEAN REGELMAN/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SLEEPY HOLLOW CEMETERY 5/9/2008 SLEEPY HOLLOW, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facili FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 3 MERCERO 200 S. HARRISON ST., EASTON, MD 21601 Approximate Interval Between Onset and Deal 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) neum ona tra Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or Items 23a or 28a-f show Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examiner once.

Baltimore, Maryland 21215-0036

Funeral Director

Be Completed by

P

death with the Maryland

Examine sician and burial-trans Physician/Medical þ Completed Be P Certification: within 24 hours aft.

To the Funeral DI

completely filled in Medical

|   | d  |                                |                          |   |   |
|---|--|--------------------------------|--------------------------|---|---|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown | 23c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Fete 4 ☐ Pregnant at time of c | al death 3 □Ectopic            | pregnancy<br>(specify)   |   | 23d. Date of delivery<br>Month Day Year                       |
| Part II. Other significant conditions co  | ntributing to death but not res  | ulting in the underlying       | g cause given in Part I. | 23e. Did tobacco                        | use contribute to the cause of death?                         |
| Hy serterson  |  |                                |                          | 1 ☐ Yes                                 | 26No 3 Probably 4 Unknown                                     |
| Dementer Cle  | is herren  | y pe                           | no                       | 24a. Was an autopsy performed:          |   |
| 25. Wa case referre o medical   | 0  |                                | 26. Place of De          | eath Check onl one                      |   |
| examiner? 1 Yes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatient 3                | DOA Other: A Nursing     | Home 5 ☐ Residence                      | 6 □Other (Specify)  |
| 27. Many er of Death 1 Natural 5 Pending 2 Accident investigation                     | 28a. Date of Injury<br>(Month, Day Year)   | 28b. Time of<br>Injury<br>M    | 28c. Injury at Work?     | 28d. Describe how in                    | iury occurred   |
| 3 Suicide 6 Could not be determined   | 28e. Place of injury - At h building, etc. (Speci                                    | ome, farm, street, fact<br>fy) | tory, office             | 28f. Location (Street City or Town, Sta | and Number or Rural Route Number,<br>te)                      |
|   | sician: To the best of my knoiner: On the basis of examinating and manner stated.    |                                |                          |   | (s) and manner as stated.  Ind place, and due to the cause(s) |

29c. License number

29d. Date Signed (Month, Day, Year)

15

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certified

M.D., 501 DUTCHMANS LANE, EASTON, MD 21601 WILLIAM H. WOOD, JR.

State Registrar

|                                |  |                         | 1 - For<br>State<br>Registrar  | State of Marylan  |  | rtificate of  |   | -                                    | glene<br>Reg. No. 20                 | 08                       | 17122                                       |
|--------------------------------|--|-------------------------|--|---|--|---|---|--------------------------------------|--------------------------------------|--------------------------|---|
|                                | Physici<br>/Medic  |                         | 1. Decedent's Name (First, Middle, Last)  FLORENCE D.  |   | THOMPS                                 | ON  |   | 2. Date of De<br>Month<br>05         | Day 20                               | Year<br>08               | 3. Time of Death                            |
|                                | Examir   |                         | 4a. Facility Name (If not institution, give www.memorial)  | ,   |  | 4b. City, Town, o   | r Location of Death                                     |                                      | 4c. County                           | of Death<br>LEGAN        | īv  |
|                                | Funeral<br>Director  |                         | 5. Social Security Number 6. Sec. 218-38-2376  |   | last birthday)<br>Yrs.                 | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Bir<br>(Month, Da         | th<br>ay, Year)                      |                          | ace (State or Foreign                       |
|                                | /land<br>ow<br>at  |                         | Usual Residence of Decedent  10a. State 10b. County  | 10c. Cit  | y, Town or Lo                          | cation  |   |                                      |                                      | 10                       | Od. Inside City Limits                      |
|                                | e Mary<br>Ba-f sh<br>ptiffed   | ctor                    | MD Allega  | ny  | Cumbe                                  | rland   |   |                                      |                                      |                          | 1 ☐ Yes 2 💢 No                              |
|                                | th with the 23a or 2 ust be no   | <b>Funeral Director</b> | 10e. Street and Number<br>14404 Old Hanco  | ck Road, NE   |  | 10f. Zip Code   | 21502   |                                      | 10g. Citizen of W                    |                          | try?  |
| 980                            | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Me-lical Examiner must be notified at |                         | 11. Marital Status  1 □ Never Married 2 □ Married  3 ሺ Widowed 4 □ Divorced  | 12. Was Decedent Ever in U.<br>Armed Forces?<br>1 □ Yes 2 ☑ No<br>If Yes, Give<br>Year or Dates:    |  | Was Decedent of H<br>f Yes, specify Cuba<br>1 □ Yes 2ሺ No | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.)      | 14. Race<br>Blac<br>Specify          | - America<br>k, White, e |   |
| 5-0                            | "natur   | leted                   | 15. Decedent's Edu<br>(Specify only highest grade  | cation<br>e completed)  | 16a. Deced                             | lent's Usual Occup  | eation<br>during most of work<br>d)                     | ing                                  | 16b. Kind of Bu                      | siness/Ind               | lustry                                      |
| 2121                           | d withir<br>giene.<br>r than<br>the Me   | Completed by            | Elementary/Secondary (0-12)  | College (1-4or 5+)  |  | Homemaker   |   |                                      | Hom                                  | ie                       |   |
| pui                            | be filed<br>ntal Hygi<br>d other<br>event, ti  | Be                      | 17. Father's Name (First, Middle, Last) Wilbur   | Mowe  | n                                      |   | 18. Mother's Name                                       | e (First, Middle,                    |                                      | •                        | _   |
| ıryla                          | 2 should to and Meni rs marked raumatic e  | ို                      | 19a. Informant's Name/Relationship (Ty)  |   |  | a Address (Street   | Mary<br>and Number or Run                               | al Route Numb                        |                                      | pence                    |   |
| , Ma                           | and 2<br>ealth a<br>n 27 Is<br>ier trau  |                         | Elmer Hornbrook /  |   | 14404                                  | Old Hand  | cock Road   |                                      |                                      |                          |   |
| ore                            | Pages 1<br>nent of He<br>int: If iten  |                         | 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ R  | emoval from State   | cemetery, crer                         | sition (Name of<br>natory or other place                  | ce)   | Date                                 | 20c. Location -                      |                          | •   |
| Baltimore, Maryland 21215-0036 | # 분원증  |                         | 4 Donation 5 Dother (Specify)  21. ig ature of Funeral Service Doens   |   |  |   | Park 05/05<br>ss of Facility Ada                        |                                      | Cumber<br>ily Fune                   |                          | MD<br>lome, F.A.                            |
| ä                              | Depa<br>Impo<br>any Ir   |                         | Hur & Ud   | ams   | 4(                                     | 04 Decatu   | ır Street   | , Cumber                             | rland, M                             |                          | 1502  |
|                                | Physician<br>/Medical  |                         | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  | rrest,  | >                                      | Approximate Interval Between Onset and Death 6 years      |   |                                      |                                      |                          |   |
|                                | Examiner   |                         | Convention liet and disease  | Due to (or as a conseq  | uence or):                             |   |   |                                      |                                      |                          |   |
| ē                              | ed sit   | iner                    | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events  | Due to (or as a conseq  | uence of):                             |   |   |                                      |                                      |                          |   |
| 68760,                         | tificate be executed<br>g physician and<br>as the burial-transit   | al Examiner             | that initiated events resulting in death) Last   | Due to (or as a conseq  | uence of):                             |   |   |                                      |                                      |                          |   |
| P.O. Box 687                   | The law requires that the death certificate ate has been signed by the attending phyy age 2 should be detached for use as the  | by Physician/Medical    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome pf pregna<br>1 □Live birth 2 □ Feta<br>4 □ Pregnant at time of d<br>9 □ Unknown | ıl death 3 □                           | Ectopic pregnancy   | /   |                                      | 23d. Dat                             | e of delive              | ry<br>Day Year                              |
| rds, P.                        | quires that<br>n signed by<br>ald be deta  |                         | Part II. Other significant conditions cor  | tributing to death but not res  | ulting in the ur                       | nderlying cause giv                                       | en in Part I.   | 23e. Did t                           |                                      |                          | e cause of death?                           |
| Division or Vital Records,     | The law re<br>ate has bee<br>page 2 shor   | Completed               |  |   |  | <u>-</u> -  |   | 24a. Was<br>autor<br>perfo<br>1∐ Yes | psy property pormed?                 |                          | osy findings available npletion of cause of |
| Viita                          | siclan:<br>certific<br>rector,   | Be                      | 25. Was case referred to medical examiner?   | lospital: 🎿   | FD/0                                   | t 3 DOA Oth   | 26. Place of Deat                                       |                                      | one)                                 |                          |   |
| ion or                         | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | ition: To               | 1 Yes 2 No Canal No C | Ospital: 1 Inpatient 2   28a. Date of Injury (Month, Day Year)                                      | ER/Outpatien<br>28b. Time of<br>Injury | 28c. Injur<br>Wor   | 4 Li Nursing Ho   |                                      | dence 6 □Othe<br>how injury occurre  |                          | )   |
| Divis                          | tal or Atters after dea al Directored in by the  | Certification:          | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of injury - At ho building, etc. (Specif   |  | eet, factory, office                                      |   | 28f. Location (3<br>City or Tov      | Street and Numbe<br>wn, State)       | er or Rurai              | Route Number,                               |
|                                | To the Hospital within 24 hours a To the Funeral I completely filled   | Medical                 | 29a. Certifier (Check only one)  Certifying Physical Control on the control on th | lician: To the best of my kno<br>ner: On the basis of examina<br>and manner stated.                 | wledge, death<br>tion and/or in        | n occurred at the tir<br>vestigation, in my o             | me, date and place,<br>opinion, death occur             | and due to the red at the time,      | cause(s) and ma<br>date and place, a | nner as st<br>and due to | ated.<br>the cause(s)                       |
|                                |  | Me                      | 29b. Signature and title of certifier  | 173   |  | 29c. Licens   | e number  |                                      | 29d. Date signed                     | (Month, I                | Day, Year)                                  |
|                                | 3  |                         | 20 Name and address of   | maleted several of facility (1)   | 200\ /T                                | D2337   | 71  |                                      | May                                  | 3,2                      | 006   |
|                                | nds  |                         | 30. Name and address of person who co<br>Qamar U. Zaman,   | M.D., 904 Se  | eton Dr                                | rive, Cum   | berland,  | MD 215                               | 502                                  |                          |   |
|                                | Sta<br>Registr   |                         | 31. Date filed (Month, Day, Year) MAY 0 5 200  | 32 Registrar's Signa  | S. Sp                                  | arte  |   |                                      |                                      |                          |   |

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To the within 2

State Registrar

MD ROWLKY 31. Date filed (Month, Day, Year) 0 6 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

32. Registrar's Signature

610

29c. License number

UTCHMANS

29d. Date signed (Month, Day, Year)

within 2 2

> State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature been & front

1328 Southern avenue

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAY 1 3 2008

Richard

D0055120

SE Sute 310

Washington Dc 20032

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8,2008 Natalie Werther Shirley 1520 May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Hospital Olney Montgomery General Date of Birth (Month, Day, Year) 1/02/1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Days 1 □ M 2 🖾 F Months Hours 83 Pennsylvania 198-12-5834 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Silver Spring 1 □Yes 2 No MD Montgomery 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code USA 20906 15101 Interlachen Drive #414 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐Yes 2 ☑No Specify. Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Denistry Dental Hygienist 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lillian Ross Samuel Klein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod2090619a. Informant's Name/Relationship (Type. Print) 15101 Interlachen Dr. #414 Silver Spring, Md Lester Werther/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Beltsville, Md 5/12/2008 Chesapeake Crem 4 ☐ Donation 5 ☐ Other (Specify) PATETED ADDIES THALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MA disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE:

Physician /Medical Examiner Examine

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Ihe M

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

Director

Funeral

Completed by

Be

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r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed sician and burial-trans the attending p for use as 1 signed by the a d be detached f has e 2 s Hospital or Attending Physician: The

Physician/Medical

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Be Completed

Certification: To

Medical

30. Name and address

Box 68760.

P.0.

Division of Vital Records,

After this certificate hit funeral director, page ithin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu

| 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ho 9 □ Unknown | 1 Live birth 2 Fet: 4 Pregnant at time of 9 Unknown | al death 3 ☐ Ectop          | ic pregnancy<br>(specify)           |   | 23d. Date of delivery<br>Month Day Year                          |
|--|---|-----------------------------|-------------------------------------|---|--|
| Part II. Other significant conditions of                                     | contributing to death but not res                   | sulting in the underlyin    | g cause given in Part I.            | 23e. Did tobacc                           | o use contribute to the cause of death?                          |
| Press  | monin ends  | empye.                      | ma                                  | 1 ☐ Yes                                   | 2 No 3 Probably 4 Unknown  |
|  |   |                             |                                     | 24a. Was an autopsy performed             |  |
| 25. Was case referred to medical   |   |                             | 26. Place of De                     | eath (Check only one)                     |  |
| examiner?<br>1☐ Yes 2,☐TNo   | Hospital: 1 ☐ Inpatient 2 €                         | ER/Outpatient 3 □           | DOA Other: 4 Nursing                | Home 5 ☐ Residence                        | 6 ☐Other (Specify)   |
| 27. Manner of Death<br>1 ☑ Natural 5 ☐ Pending<br>2 ☐ Accident investigation | 28a. Date of Injury<br>(Month, Day, Year)           | 28b. Time of<br>Injury<br>M | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No | 28d. Describe how in                      |  |
| 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined                       |   | nome, farm, street, fac     | tory, office                        | 28f. Location (Street<br>City or Town, St | and Number or Rural Route Number,<br>ate)                        |
|  | and manner stated                                   | ation and/or investiga      | tion, in my opinion, death oc       |   | e(s) and manner as stated.<br>and place, and due to the cause(s) |
| 29b. Signature and title of certifier  | Lay De  | ficul Dire                  | 9c. License number                  |   | Date signed (Month, Day, Year)                                   |

20832

State Registrar

To the within 2.

5

of person who completed cause of death (Item 23a) (Type, Print)

|   |                | For<br>1_ State   | State of M                                     | laryland       |                  | rtment of<br>tificate o              |                        | and Mental                                |                               | 2000                       | 1712   |
|---|----------------|---|--|----------------|------------------|--------------------------------------|------------------------|---|-------------------------------|----------------------------|--|
| -   |                | 1 State Registrar  1. Decedent's Name (First, Middle, L   | acti   |                | Cei              |                                      | Dealli                 | 2. Date                                   | Reg.                          | No.                        | 3. Time of Death                                 |
| Physicia  | an             | Dorothy Wollett   | .ast)  |                |                  |                                      |                        | Monti                                     |                               | Day 2008                   | 1:30 PM  |
| /Medic  |                | 4a. Facility Name (If not institution, g  | ivo etreet and number                          | 1              |                  | 4b. City, Town                       | or Location            |   | 10                            | 4c. County of Death        | 1.50 1   |
| Examin  | er             | Snow Hill Nursin  |  |                | r                | Snow H                               |                        | of Death                                  |                               | Worcester                  |  |
| Funeral   |                |   |  | ge (In yrs. la |                  | If Under 1 Ye                        |                        | 24 Hrs. 8. Date                           | of Dieth                      | O Diethi                   | place (State or Foreign                          |
| Funeral<br>Director   |                | 218-16-9954   | 1 □ M 2 💢 F                                    | 83             | Yrs.             | Months Day                           | s Hours                | Min. Jan.                                 | $^{h, Day, Ye}$               | 1925 Mary                  | Land   |
| 0 100 mm  |                | Usual Residence of Decedent   |  |                |                  |                                      |                        |   |                               |                            |  |
| ıryları<br>show   | _              | 10a. State 10b. County  |  | 10c. City,     | Town or Lo       | cation                               |                        |   |                               |                            | 10d. Inside City Limits<br>1 X Yes 2 ☐ No        |
| Ba-f s  | cto            | Maryland   Worcest  | er   | Sno            | ow Hil           |                                      |                        |   |                               |                            |  |
| vith the  | Director       | 10e. Street and Number  |  |                |                  | 10f. Zip Code                        |                        |   | 10g. Citizen of What Country? |                            |  |
| s 23s   | sral           | 430 West Market   |  | Ever in II C   | 140.1            | 218                                  |                        | ining (Chaoify Voc                        | or No.                        | USA<br>14. Race - Americ   | can Indian                                       |
| ter de  | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☐ Married  | 12. Was Deceden<br>Armed Forces<br>1 ☐ Yes 2 🔀 | ?              | . 13. 1          | f Yes, specify C                     | uban, Mexica           | igin? (Specify Yes<br>n, Puerto Rican, et | ).)                           | Black, White,              |  |
| rs afi  | by F           | 3 XWidowed 4 Divorced   | If Yes, Give<br>Year or Dates:                 |                |                  | I∐Yes 2⊠N                            | lo Specify:            |   |                               | Specify: Wh                | ite  |
| 2 hou<br>atura<br>cal E   | ed             | 15. Decedent's  |  | - 17           | 16a. Deced       | lent's Usual Occ                     | cupation               |   | 16b                           | o. Kind of Business/Ir     | dustry   |
| hin 7;<br>e.<br>an "n<br>Medi   | ple            | (Specify only highest of Elementary/Secondary (0-12)  | rade completed) College (1-4or                 | 5+)            | (Give<br>life. L | kind of work doi<br>OO NOT use ret   | ne during mos<br>ired) | t of working                              |                               |                            |  |
| d with  | Completed      | 8   |  | - /            | H                | Homemake                             | r                      |   |                               | Own Ho                     | me   |
| al Hy<br>al Hy<br>oth   | Be             | 17. Father's Name (First, Middle, La  | -  |                |                  |                                      |                        | er's Name (First, M                       |                               |                            |  |
| Ment<br>Ment<br>arked<br>arked  | ည              | Harry E. Hughes   | 3  |                |                  |                                      |                        | Della Br                                  |                               |                            |  |
| 2 short   |                | 19a. Informant's Name/Relationship  | . Broth  | er             |                  | •                                    |                        |   |                               | ity or Town, State, Zi     | o Code)  |
| and<br>lealth<br>m 27<br>her to   |                | Paul B. Davenpo   | rt/ In-La                                      |                |                  |                                      | yier                   | na, MD 2                                  |                               | Landing City of T          | cura Ctata                                       |
| ges 1<br>t of F<br>Fite<br>or ot  |                | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3   | ☐Removal from State                            | e ce           | metery, crer     | sition (Name of<br>natory or other p |                        |   |                               | c. Location - City or T    |  |
| t. Pa<br>tmen<br>tant:<br>tant:   |                | 4 □ Donation 5 □ Other (Spe   | 11   | Bro            |                  | v Cemete                             |                        | 5/14/2008                                 |                               | cookview,                  | Maryland   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time Z1 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. |                | 21. Sign, tupe of Fureral Service Lie   | en S   | De             | Ze               | eller Fi<br>06 Mains                 | ineral<br>Street.      | Home, P.<br>East Ne                       | O. E                          | Box 207<br>ket, MD 2       | 1631   |
|   |                | 23a. Part . Enter the disease, or co<br>shock, or heart failure. List on  | mplications that cause                         | ed the death.  |                  |                                      |                        |   |                               |                            | Approximate<br>Interval Between                  |
| Physician   | 0.3            | Immediate Cause (Final  | ly one bause on each                           |                | A                | tros                                 |                        |   |                               |                            | Onset and Death                                  |
| /Medical  |                | disease or condition resulting in death)  | и.   | s a conseque   |                  | 1 6160 36                            | LEIL                   | 917                                       |                               |                            |  |
| Examiner  |                |   |  |                | •                |                                      |                        |   |                               |                            |  |
| Walter Day  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b. Due to (or a                                | s a conseque   | ence of):        |                                      |                        |   |                               |                            |  |
| cutec<br>nd<br>ransi  | Examin         | Cause (Disease or injury that initiated events  | с  |                |                  |                                      |                        |   |                               |                            |  |
| e exe<br>lan ar<br>ırial-t  | EX             | resulting in death) Last  | Due to (or as a consequence of):               |                |                  |                                      |                        |   |                               |                            |  |
| cate be executed<br>physician and<br>the burial-transit   | dical          |   | d  |                |                  |                                      |                        |   |                               |                            |  |
| Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit   | 0              | IF FEMALE:  |  |                |                  |                                      |                        |   |                               | I                          |  |
| leath certific<br>attending p   | Physician/M    | 23b. Was decedent pregnant in the past 12 months?   | 23c. If yes, outcom<br>1 ☐Live birth           | 2 Fetal        | death 3□         | Ectopic pregna                       |                        |   |                               | 23d. Date of delive        | rery<br>Day Year                                 |
| he de<br>the a  | /sic           | 1 ☐ Yes 2 ☑ No<br>9 ☐ Unknown   | 4□Pregnant<br>9□Unknown                        | at time of de  | ath 5∟           | Other (specify                       | )                      |   | _                             |                            | ŕ  |
| w requires that th<br>been signed by t<br>should be detach  |                | Part II. Other significant conditions   | s contributing to death                        | but not resul  | ting in the u    | nderlying cause                      | given in Part          | I. 23e.                                   | Did tobac                     | co use contribute to       | the cause of death?                              |
| signe<br>d be   | l by           |   |  |                |                  |                                      |                        |   | 1 🗆 Yes                       | 2  No 3  Pro               | bably 4 Unknowr                                  |
| requent should  | etec           |   |  |                |                  |                                      |                        | 240                                       | Was an                        | 24h More out               |  |
| has has ye 2 s  | Completed      |   |  |                |                  |                                      |                        |   | autopsy                       | prior to c                 | opsy findings available<br>ompletion of cause of |
| ilclan: The certificate harerector, page  |                | 05 W  |  |                |                  |                                      |                        |   | Yes 2                         | No 1 ☐ Yes                 | 2 No   |
| yslclan<br>is certifi<br>director,  | Be (           | 25. Was case referred to medical examiner?  1 Yes 2   | Hospital:                                      | tiont 200      | EP/Outpation     | nt 3 DOA                             |                        | e of Death (Check                         |                               |                            | 56.3   |
| Phys<br>r this<br>ral di  | . To           | 27. Manner of Death   | 28a. Date of In                                | jury           | 28b. Time o      |                                      | njury at<br>Vork?      |   |                               | ce 6 Other (Specification) | пу)  |
| ding I<br>h.<br>After<br>funer  | tion           | 1 Alatural 5 ☐ Pending 2 ☐ Accident investigat  | (Month, E                                      | Pay Year)      | Injury           |                                      | Vorƙ?<br>☐Yes 2☐       | No  |                               |                            |  |
| Atter   | fica           | 3 ☐ Suicide 6 ☐ Could not   | ad Zoe. Place of it                            |                |                  | eet, factory, offi                   | ce                     |   |                               | et and Number or Ru        | ral Route Number,                                |
| al or s after   | Certification: | 4 ☐ Homicide determine  | building,                                      | etc. (Specify) | ,                |                                      |                        | City                                      | or Town, S                    | oldte)                     |  |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer  |                |   | Physician: To the bes                          |                |                  |                                      |                        |   |                               |                            |  |
| he H(<br>in 24<br>he Ft   | Medical        | (Check only 2 Medical Ex  | aminer: On the basis<br>and manner             |                | on and/or in     | vestigation, in n                    | iy opinion, de         | au occurred at the                        | urne, date                    | e and place, and due       | to the cause(s)                                  |
| To t<br>withi<br>To tl  | ž              | 29b. Signature and title of certifier   | J M.   |                |                  |                                      | ense number            |   |                               | . Date signed (Month       |  |
|   |                | ) Jan   | IN .   | , .            |                  | 06                                   | 2172                   | 2   | -                             | 5/12/20                    | 08   |

State Registrar 31. Date filed (Month, Day

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
SHARAD R. SATYAL, M.D. 1604 MARICET ST. POCOMOKE CITY, MD

|   |                | For<br>State<br>Registrar   | State of Marylan  | •                                | artment of H   |                          | d Mental Hy                       | giene<br>Reg. No. 2 | 008                               | 17128                               |
|---|----------------|---|---|----------------------------------|--|--------------------------|-----------------------------------|---------------------|-----------------------------------|-------------------------------------|
| 8   |                | Decedent's Name (First, Middle, La  | ast)  |                                  |  |                          | 2. Date of D                      | eath                | Vees                              | 3. Time of Death                    |
| Physici<br>/Medic   |                | PHILLIP   | BERNAR  | D Y                              | OUNG   |                          | MAY                               | 8 20                | 008 <sup>Year</sup>               | 11:12A M                            |
| Examir  |                | 4a. Facility Name (If not institution, gi                                     | ve street and number)                                     |                                  | 4b. City, Town, or                                     |                          |                                   |                     | inty of Death                     | on and a                            |
|   |                | 7737 OXMAN ROA  |   |                                  |  | ATTSVI                   |                                   |                     | NCE GE                            |                                     |
| Funeral   |                |   | Sex 7. Age (In yrs. 1 ☑ M 2 ☐ F                           | last birthday)<br>Yrs.           | If Under 1 Year<br>Months Days                         | If Under 24 H<br>Hours M | in. 8. Date of B. (Month, D. FEB. | irth<br>19 1962     | Coun                              | **                                  |
| Director  |                | 579-86-5004 Usual Residence of Decedent                                       | 46  |                                  |  | 1                        | I LLD.                            | 17 1702             | Was                               | h. D.C.                             |
| ryland<br>how   |                | 10a. State 10b. County  |   | y, Town or Lo                    | cation   |                          |                                   |                     | 11                                | 0d. Inside City Limits              |
| Ba-f s  | Director       | MD PRINCE G   | EORGES LAN  | DOVER                            |  |                          |                                   |                     |                                   | 1 AYes 2 No                         |
| a or 2<br>be no   |                | 10e. Street and Number 7737 OXMAN ROAD  |   |                                  | 10f. Zip Code<br>20785                                 |                          |                                   | USA                 | of What Coun                      | try?                                |
| eath v  | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U.                               | S 13 1                           | 3. Was Decedent of Hispanic Origin? (Specify Yes or No |                          |                                   |                     | Race - America                    | an Indian.                          |
| fter d<br>r item<br>iner  | Fun            | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give                 |                                  | If Yes, specify Cuba                                   | n, Mexican, Pu           | uerto Rican, etc.)                |                     | Black, White,                     | etc.                                |
| urs a<br>ai", ο<br>Exaπ   | þ              | 3 ☐ Widowed 4 ☐ Divorced  | If Yes, Give Year or Dates:                               |                                  | 1 □ Yes 2 🖺 No   | Specify:                 |                                   | Spe                 | ecify: BLA                        |                                     |
| 72 hc<br>'natuı<br>dicai  | Completed      | 15. Decedent's E<br>(Specify only highest gi                                  |   | (Give                            | dent's Usual Occupa<br>kind of work done d             | luring most of v         | working                           | 16b. Kind o         | f Business/Inc                    | lustry                              |
| vithin<br>ane.<br>Ihan *  | ם              | Elementary/Secondary (0-12)   | College (1-4or 5+)  |                                  | DO NOT use retired, RY TECHNI                          |                          |                                   | PRIV                | ATE                               |                                     |
| filed v<br>Hygie<br>ther t  |                | 12TH 17. Father's Name (First, Middle, Las                                    | t)  |                                  |  |                          | Name (First, Middle               |                     |                                   | ····                                |
| ld be<br>ental<br>ked o   | To Be          | JAMES E. ODOM   | ,   |                                  |  | THERES                   | SA J. YOU                         | NG                  |                                   |                                     |
| shou<br>and M<br>s mar<br>umat  | -              | 19a. Informant's Name/Relationship  | (Type. Print)   | 19b. Mailir                      | ng Address (Street a                                   |                          |                                   |                     | wn, State, Zip                    | Code)                               |
| and 2<br>salth a<br>n 27 is   |                | THERESA YOUNG/MOT   |   |                                  | OXMAN RO   | AD LAND                  | OVER, MD                          | 20785               |                                   |                                     |
| ges 1<br>t of H <sub>k</sub><br>if iten<br>or oth   |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [                       |   | Place of Dispo<br>cemetery, crei | sition (Name of<br>matory or other place               | e)                       | Date                              | 20c. Location       | on - City or To                   | wn, State                           |
| t. Partmen  |                | 4 Donation 5 Other (Spec  | 4   |                                  | MEMORIAL   |                          | 15/2008                           |                     |                                   |                                     |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                | 21. Signature of Funeral Service Lice   | nsee  |                                  | 2. Name and Addres                                     | -                        | J. B. J                           |                     |                                   |                                     |
|   |                | 23a. Part . Enter the disease, or cor   | nplications that caused the deat                          |                                  | 7474 LANDO   |                          |                                   |                     | AKILANL                           | Approximate                         |
| Physician   |                | shock, or heart failure. List only<br>Immediate Cause (Final                  | one cause on each line.  METASTATIC (                     | CARCING                          | מסאווד חדר   |                          |                                   |                     |                                   | Interval Between<br>Onset and Death |
| /Medical  |                | disease or condition resulting in death)                                      | Due to (or as a conseq                                    |                                  | JID TOHOK  |                          |                                   |                     |                                   |                                     |
| Examiner  | l. l           | Sequentially list conditions,   | b   |                                  |  |                          |                                   |                     |                                   |                                     |
| pe sit  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a conseq                                    | uence of):                       |  |                          |                                   |                     | -                                 |                                     |
| be executed<br>sician and<br>burial-transit   | xan            | that initiated events<br>resulting in death) Last                             | c<br>Due to (or as a conseq                               | uence of):                       |  |                          |                                   |                     |                                   |                                     |
| The law requires that the death certificate be executed tte has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | dical E        |   | · d   |                                  |  |                          |                                   |                     |                                   |                                     |
| tificate I<br>ig physi<br>as the b  | ledi           |   |   |                                  |  |                          |                                   |                     |                                   |                                     |
| leath certific<br>attending p<br>I for use as   | an/N           | IF FEMALE:<br>23b. Was decedent pregnant                                      | 23c. If yes, outcome pf pregna<br>1 ☐ Live birth 2 ☐ Feta |                                  | Ectopic pregnancy                                      |                          |                                   | 23d.                | Date of delive                    | *                                   |
| e dea<br>the att  | Physician/Me   | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                       | 4☐Pregnant at time of d<br>9☐Unknown                      |                                  | Other (specify)  |                          |                                   |                     | Month                             | Day Year                            |
| hat the de<br>detached  |                | Part II. Other significant conditions   | contributing to death but not res-                        | ulting in the u                  | nderlying cause give                                   | en in Part I             | 23e. Did                          | tobacco use o       | contribute to the                 | ne cause of death?                  |
| w requires that<br>been signed b<br>should be deta  | d by           |   | ,   | 3                                | , ,  |                          | 1                                 | ]Yes 2 <b>√</b> []N | o 3 Prob                          | ably 4 □Unknown                     |
| w req   | Completed      |   |   |                                  |  |                          |                                   | s an 2              | 4b. Were auto                     | psy findings available              |
| The laverate has page 2:  | d d            |   |   |                                  |  |                          | per                               | opsy<br>formed?     | prior to cor<br>death?<br>1 ☐ Yes | npletion of cause of                |
|   | a l            | 25. Was case referred to medical  |   |                                  |  | 26. Place of I           | 1□ Yes<br>Death (Check only       |                     | T Tes                             | 2页 No                               |
| hysici<br>nis ce<br>I direc   | To B           | examiner?<br>1 ☐ Yes 2 🔀 No   | Hospital: 1 ☐ Inpatient 2 ☐                               | ER/Outpatier                     | nt 3□ DOA Othe   | er:<br>4 🗆 Nursin        | g Home 5₺ Re                      | sidence 6 🗆         | Other (Specify                    | y)                                  |
| iding Physician: th. After this certifica   |                | 27. Manner of Death  1 X Natural 5 ☐ Pending                                  | 28a. Date of Injury<br>(Month, Day Year)                  | 28b. Time o<br>Injury            | Work   | (?                       | 28d. Describe                     | how injury oc       | curred                            |                                     |
| or Attending after death. Director: After in by the funer   | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not leads                    |   | ama farm etr                     |  | Yes 2 □ No               | 20f Location                      | (Ctrant and ti      |                                   | I Dayta Mumbar                      |
| or A  | artifi         | 4 ☐ Homicide determined   | 28e. Place of injury - At he building, etc. (Specif       |                                  | eet, factory, office                                   |                          |                                   | own, State)         | umber or Hura                     | l Route Number,                     |
| spital or<br>nours afte<br>neral Dir<br>/ filled in   | a C            |   | hysician: To the best of my kno                           |                                  |  |                          |                                   |                     |                                   |                                     |
| To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certification of the funeral director, completely filled in by the funeral director,  | edical         | (Check only 2 ☐ Medical Exa   | miner: On the basis of examina<br>and manner stated.      | ation and/or in                  | vestigation, in my o                                   | pinion, death o          | occurred at the time              | e, date and pla     | ace, and due to                   | the cause(s)                        |
| To the sound  | Me             | 29b. Signature and title of certifier   |   |                                  | 29c. License   | number                   |                                   | 29d. Date si        | gned (Month,                      | Day, Year)                          |
| (2)   |                | ME  | -1 /eee   |                                  | D0023  | 3125                     |                                   | MAY                 | 9, 2                              | 800                                 |
| íso   |                | 30. Name and address of person who  |   |                                  |  | ITTE 10                  | O DIUDDO                          | ATT: NOT            |                                   |                                     |
| Sta   | ato            | MADHU K. MOHAN,  31. Date filed (Month, Day, Year)                            | M.D. 6502 KENTI<br>32. Registrar's Sign                   | ture _                           | AVENUE SI  | DITE 10                  | U KIVERD.                         | ALE, MI             | 20/37                             |                                     |
| ) J   | ate.           | MAY 1 3 2008  | La K L  | 200                              |  |                          |                                   |                     |                                   |                                     |

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

10+1

State Registrar 6565 NOTTH Charles

32. Registrar's Signature

Black

31. Date filed (Month, Day, Year)

Suite 209, Towson MD 21204

law requires that the death certificate be executed Box 68760, Records, P.O. **ALEXANDER** of Vital To the Hospital or Attending Physician: Division within 24 hours arter control to the Funeral Director; Aff

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

Š

Completed

Be ပ

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evantines must be notified at once.

Physician

/Medical

Examiner

physician and s the burial-trans

attending p for use as use as

s been signed by the should be detached

s certificate has b irector, page 2 sh

: After this certification funeral director, p

Baltimore, Maryland 21215-0036

/Medical

10a, State

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed Be 25. Was case referred to medical examiner? 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 K Natural 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number 21108

State

Registrar

TARIQ MAHMOOD 31. Date filed (Month, Day, Year)
MAY 2 8 2008

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

TIMONIUM, MD 21093

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|   |  |                  | 1 - For<br>State<br>Registrar   | State of Ivia  | arylario /                            | •                            | ificate of  | Death                                     |   |                          | 2008                         | 171                          | 31       |
|---|--|------------------|---|--|---------------------------------------|------------------------------|---|---|---|--------------------------|------------------------------|------------------------------|----------|
|   | Physici  |                  | Decedent's Name (First, Middle     FRONA                                      | e, Last)   |                                       |                              | ALL   | FN  | 2. Date of Dea<br>Month<br>WAY            | th 2av 24                | 2008                         | 3. Time of Dea<br>7:58P      | ath<br>M |
|   | /Medio   |                  | 4a. Facility Name (If not institution   | n, give street and number)   |                                       |                              |   | r Location of Death                       |   |                          | unty of Death                |                              |          |
|   |  |                  | MILFORD MANOR   |  |                                       |                              | BALTIMO   |   |   |                          | TIMOR                        | <u>.</u>                     |          |
|   | Funeral<br>Director  |                  | 5. Social Security Number 218-18-3677 Usual Residence of Decedent             | 6. Sex 7. Ag<br>1 □ M 2 💢 F  | ge (In yrs. last<br>85                |                              | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birtl<br>(Month, Day<br>07/11, | 1922                     | 9. Birth                     | pplace (State or Fountry) MD | reign    |
| ryland  | how  | L                | 10a. State 10b. County  |  | 10c. City, To                         | own or Loca                  | tion  |   |   |                          |                              | 10d. Inside City L           |          |
| ле Ма   | 8a-f s   | ecto             | MD BALTI  | MORE   | BALT                                  | TIMORE                       |   |   |   |                          |                              | 1 □ Yes 2 [                  | (No      |
| with t  | Sa or 2  | ij               | 10e. Street and Number<br>4204 OLD MILF                                       | ORD MILL ROA   | ΔD                                    |                              | 10f. Zip Code   | 21208                                     |   | 10g. Citizer             | of What Cou<br>USA           | intry?                       |          |
| death   | ems 2  | Funeral Director | 11. Marital Status  | 12. Was Decedent   | Ever in U.S.                          | 13. Wa                       |   | Hispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No-                         | 14.                      | Race - Amer<br>Black, White  |                              |          |
| <b>5-UU36</b><br>72 hours after death with the Maryland | ne.<br>than "natural", or items 23a or 28a-f show<br>"Medical Extrainer court be notified at   | by               | 1 ☐ Never Married 2 ☐ Marr<br>3 ሺ Widowed 4 ☐ Divorced                        | Armed Forces?<br>ied 1 □Yes 2 🕅<br>If Yes, Give<br>Year or Dates:      | No                                    |                              | ∃Yes 2 X No   | Specify:                                  |   |                          |                              | HITE                         |          |
| 15-0  | "natur   | letec            | 15. Deceden<br>(Specify only higher   | t's Education<br>st grade completed)                                   | 10                                    | 6a. Decede<br>(Give ki       | nt's Usual Occup<br>nd of work done                   | oation<br>during most of wor<br>d)        | king                                      | 16b. Kind                | of Business/I                | ndustry                      |          |
| ZTZ<br>Z within   | ¥ 1 5  | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5   | 5+)                                   |                              |   | R COORDIN                                 |   | ı                        | HEALTH                       | CARE                         |          |
| yland<br>ould be filed                                  | permit. Fages 1 and 2 should be lited<br>Department of Health and Mental Hyg<br>Important: If item 27 is marked other<br>any injury or other traumatic event,<br>once. | To Be C          | 17. Father's Name (First, Middle, SAUL  | Last)  | BAF                                   | RDOFF                        |   | 18. Mother's Nan                          | ne (First, Middle,                        | Maiden Su                |                              | DAVIS                        |          |
| Mary<br>d 2 shou  |  | -                | 19a. Informant's Name/Relations   | hip (Type. Print)  | 1                                     | 9b. Mailing                  | Address (Street                                       | and Number or Ru                          | ıral Route Numbe                          | r, City or To            | own, State, Z                | ip Code)                     |          |
| 6, <b>≥</b>   | Health<br>em 27<br>ther tr   |                  | RICK ALLEN /  | SON  | 20h Place                             |                              | ENTURY :  | STREET,                                   | HAMPSTE/                                  |                          | D 210                        | · ·                          |          |
| Itimore,<br>iit. Pages 1 a                              | ent of<br>nt: If it<br>ry or o   |                  | 1 □XBurial 2 □ Cremation<br>4 □ Ponation 5 □ Other (S                         |  | ANS                                   | E CEN                        | ONAH CONG   | <sup>(2e)</sup>                           | 5/2008                                    |                          |                              |                              |          |
| Balti<br>permit.  | epartm<br>nportal<br>ny inju   | 1                | 21. Jonatu For Funeral Service  | 1-//   | AL                                    | 22.1                         | Name and Addre  |   | OL LEVINS                                 |                          |                              |                              |          |
| ם או  | ă E a a  | 1                | 23a. Part 1. Enter the disease, or  | Mugel  | (S) do allo . I                       | 89                           | 00 REIS   | TERSTOWN                                  | ROAD, P                                   | IKESV                    | ILLE,                        | MD 21208<br>Approximate      | 3        |
| Dh  | ysician  | 8 6              | Immediate Cause (Final  | only one of se on each li  | ne.                                   | (tu                          | The mode of dy  | Huento                                    |   | rest,                    |                              | Interval Betwee              | th       |
| //\   | ledical  |                  | disease or condition resulting in death)                                      | Due to (or as  | a consequenc                          | ce of):                      | 1   |   |   |                          |                              | WANTED.                      |          |
| EX  | aminer   | ie e             | Sequentially list conditions,   | b. Due to for as   | a consequenc                          | es offe.                     |   |   |   |                          |                              |                              |          |
| cuted   | nd<br>ransit   | Examiner         | cause. Enter Underlying Cause (Disease or injury that initiated events        | c.   |                                       |                              |   |   |   |                          |                              |                              |          |
| bu,<br>be exe   | ig physiclan and<br>as the burial-transit  |                  |   |  |                                       |                              |   |   |   |                          |                              |                              |          |
| <b>5875U</b><br>rtificate be                            | g phys<br>as the   | Medical          |   | d  |                                       |                              |   | ***                                       |   |                          |                              |                              | -,       |
| death ce  | has been signed by the attendin<br>le 2 should be detached for use a   | Physician/M      | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a                     | 2 Fetal dea                           | ath 3 □ E                    | Ectopic pregnanc<br>Other <i>(sp</i> ec <i>ify)</i> _ | ey  |   | 230                      | I. Date of deli<br>Month     | very<br>Day Yea              | r        |
| rat the   | d by the   | Phys             | 9 ☐ Unknown  Part II. Other significant condition                             |  | ut not ropulting                      | a in the und                 | arlying course giv                                    | ran in Port I                             | 23a Did to                                | hacco uso                | contributa to                | the cause of deat            | h2       |
| ecords, P.O<br>law requires that the                    | n signe  | d by             | 11.   | enying cause giv   | enin Fait I.                          |                              |   | _   | bably 4 🗆 Unk                             |                          |                              |                              |          |
| ecords,   | s beer<br>2 shou   | Completed        | ()  | ntension   |                                       |                              | _   |   | 24a. Was a                                |                          | 24b. Were au                 | topsy findings ava           | lable    |
| Tal He  | page p   | Com              |   |  |                                       |                              |   |   | autop<br>perfor<br>1 □Yes                 | med?<br>2 X No           |                              | ompletion of caus<br>2 □No   | ∋ 01     |
| VITE<br>sician  | certific<br>rector,  | Be               | 25. Was case referred to medical examiner?                                    | Hospital:  |                                       |                              | 3□ DOA Oth  | or:                                       | ath (Check only or                        |                          |                              |                              |          |
| OT<br>g Phy   | ter this<br>neral di   | n: To            | 1 Yes 2 No<br>27. Manner of Death   | 28a. Date of inju  | ent 2 ER/                             | b. Time of<br>Injury         | 28c. Injur  | 4 Ly Nursing H                            | lome 5 ☐ Resid                            |                          |                              | eify)                        |          |
| VISION<br>Attending                                     | eath.<br>:or: Afi<br>the fur   | catio            | 1  Natural 5  Pending 2  Accident investig 3  Suicide 6  Could r              | ation  |                                       |                              | M 1 🗆   | Yes 2 □No                                 |   |                          |                              |                              |          |
| DIVI  | s aner d<br>al Direct<br>ad in by  | Certification:   | 4 Homicide determ   |  | ury - At home,<br>c. <i>(Specify)</i> | farm, stree                  | t, factory, office                                    |   | 28f. Location (S<br>City or Tow           | treet and N<br>n, State) | lumber or Ru                 | ral Route Number,            |          |
| e Hospit  | winning thous after doean.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page                                      | Medical (        | 29a. Certifier 1 A Certifyin (Check only one) 2 Medical                       | g Physician: To the best<br>Examiner: On the basis o<br>and manner sta | of examination                        | dge, death of<br>and/or inve | occurred at the ti<br>stigation, in my o              | me, date and place<br>opinion, death occu | e, and due to the urred at the time,      | cause(s) ar              | nd manner as<br>ace, and due | stated.<br>to the cause(s)   |          |
| To th   | To the   | Me               | 29b. Signature and title of confiner  | 1.0  |                                       |                              | 29c. Licens   | se number                                 | c :                                       | 29d. Date s              | igned (Month                 | , Day, Year)                 |          |
|   | .[   |                  | 30. Name and address of person  | who completed cause of d   | leath (Item 23                        | a) (Type, Pr                 | int) -  | , 136                                     | 1   | 512                      | 5/08                         |                              |          |
|   | r  |                  | 31. Date filed (Month, Day, Year)   | Hettlen  | er's Signature                        | 18                           | 38 G  | reeno                                     | Tree                                      | . R                      | 1 2                          | 1208                         |          |
|   | Sta<br>Registr   |                  | LARV 0  | 32. Registra   | ai s Signature                        | So                           | uli   |   |   |                          |                              |                              |          |
| DHMH  | 17 Rev 1/2   | 001              | MAT A C   | , com , juiges   |                                       | ORIGI                        | VAL   |   |   |                          |                              |                              |          |
|   |  |                  |   |  |                                       | -111011                      |   |   |   |                          |                              |                              |          |

|  |                | 1 - State of I   | Maryland / Depa<br><i>Cer</i>                      | artment of Hea<br>ctificate of De   |   | ental Hygid<br>Reg                          | ene<br>3. No 200                | 8 17132  |  |  |
|--|----------------|--|--|---|---|---|---------------------------------|--|--|--|
| Physic   | ian            | Decedent's Name (First, Middle, Last)  |  | <u> </u>  |   | 2. Date of Death<br>Month                   | Day Ye                          | 3. Time of Death                                 |  |  |
| /Med   |                | Pauline Marie Budny  |  | 41. O't. Taura aslan  |   | May 24,                                     | 2008<br>4c. County of E         | 11:54p M   |  |  |
| Exam   | iner           | 4a. Facility Name (If not institution, give street and number 6810 Fait Avenue   | er)  | 4b. City, Town, or Loc Baltimo  |   |   | N/                              |  |  |  |
| <br>Funera   | 40.            | 5. Social Security Number 6. Sex 7.  | Age (In yrs. last birthday)                        | If Under 1 Year If I  | Under 24 Hrs.                                     | 8. Date of Birth<br>(Month, Day,            |                                 | Birthplace (State or Foreign Country)            |  |  |
| Directo  |                | 216-03-5745 1□M 2XIF   | 93 Yrs.  | Months Days H   | lours Min.  | 12-20-                                      | 1914                            | Maryland   |  |  |
| pur *  |                | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Lo                              | cation  |   |   |                                 | 10d. Inside City Limits                          |  |  |
| Maryla<br>f sho  | Į.             | MD N/A   | Baltin   | nore  |   |   |                                 | 1 X Yes 2 □ No                                   |  |  |
| r 28a-   | Director       | 10e. Street and Number   | Darein   | 10f. Zip Code   |   | 10  | g. Citizen of Wha               | t Country?                                       |  |  |
| th with 23a o  | a D            | 6810 Fait Avenue   |  | 21224   |   |   | USA                             |  |  |  |
| Dallilliore, Ivial yiallia 2.12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decede Armed Force 1 □ Yes 2. If Yes, Give Year or Date  | K No   | Was Decedent of Hispa<br>If Yes, specify Cuban, №<br>1 🗆 Yes 2 🔀 No <i>Si</i> | inic Origin? (Spe<br>Mexican, Puerto l<br>pecify: | city Yes or No-<br>Rican, etc.)             | Black, \                        | American Indian,<br>White, etc.<br>White         |  |  |
| A LA LO COOL<br>ad within 72 hours af<br>rgiene.<br>er than "natural", or<br>the Medical Exam  | Completed k    | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4)   | 16a. Deced   | dent's Usual Occupation<br>kind of work done durin<br>DO NOT use retired)     | n<br>ng most of worki                             |   | 6b. Kind of Busin               | ess/Industry                                     |  |  |
| d with signer of the f   | l m            | 8 N/A  |  | l Inspecto  |   |   |                                 | Electric   |  |  |
| Marylaila<br>d2 should be file<br>lth and Mental Hy<br>27 Is marked oth<br>traumatic event   | B              | 17. Father's Name (First, Middle, Last) Victor Sikorski  |  |   |   | (First, Middle, M                           | aiden Surname)<br>1 l k o w s k | •  |  |  |
| 2 should and Men Is marke  | 은              | 19a. Informant's Name/Relationship (Type. Print)   | 19b Mailir   | ng Address (Street and  |   |   |                                 |  |  |  |
| and 2 slealth an 27 Is r   |                | Eileen Budny - Daught  | 1  | ) Fait Av   |   |   |                                 |  |  |  |
| Pages 1 and 2 nent of Health int: If Item 27 I ary or other tra  |                | 20a. Method of Disposition   | 20b. Place of Dispo                                |   |   | Date 2                                      | 0c. Location - Cit              | y or Town, State                                 |  |  |
| Page<br>ment of  |                | 1 Ma Burial 2 □ Cremation 3 □ Removal from St<br>4 □ Donation 5 □ Other (Specify)  | St. Star   | nislaus C   |   |   |                                 |  |  |  |
| Dalltillore, permit. Pages 1 ar Department of Hea important: If Item any Injury or othe  |                | 21. Signature of Funeral Service Licensee  | 12   | 201 Dunda   | 1k Ave  | nue Bal                                     | timore                          | eral Home, P<br>, MD 21222                       |  |  |
| Physiciar<br>/Medica   | -              | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of): |  |   |   |   |                                 |  |  |  |
| Examine  |                | 12   | restantes  | <u> </u>  |   |   |                                 |  |  |  |
| ted<br>nsit  | Examiner       | Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events   | s a consequence of):                               | do  | the   |   |                                 |  |  |  |
| J,<br>execu<br>n and<br>ial-tra  | Exar           | resulting in death) Last  C. Due to (or  | as a consequence of):                              | denen   | 27 1 C. 1   |   |                                 |  |  |  |
| icate be executed physician and sthe burial-transit  | dical          | d. 10  | 1 partoles   | dema:   |   |   |                                 |  |  |  |
| Ords, P.O. BOX 6 requires that the death certificen signed by the attending I hould be detached for use as   | Physician/Me   | in the past 12 months?   | nt at time of death 5                              | □Ectopic pregnancy<br>□ Other ( <i>specify</i> )                              |   |   | 23d. Date of Month              |  |  |  |
| IS, P.   | b              | Part II. Other significant conditions contributing to dea  | th but not resulting in the u                      | underlying cause given i  | in Part I.  |   |                                 | ute to the cause of death?                       |  |  |
| w require  | eted           | Ofteoporelis.  |  |   |   |   |                                 | ere autopsy findings available                   |  |  |
| The la ate has page 2  | Completed      |  |  |   |   | 24a. Was ar<br>autops<br>perform<br>1 Yes 2 | y pri<br>ned? de:<br>2 X No 1 L | or to completion of cause of ath?  Yes 2 \sum No |  |  |
| Or VITa Physician: this certific ral director,   | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☐ In  | patient 2 ☐ ER/Outpatie                            | Other:  |   | h <i>(Check only on</i><br>ome 5⊠ Reside    | e)<br>ence 6 ⊟Other             | (Specify)  |  |  |
| g Physe ter this neral di  | Ë              | 27. Manner of Death 28a. Date of   |  |   |   |   | w injury occurred               | · · · · · · · · · · · · · · · · · · ·            |  |  |
| Attending r death. sctor: After by the fune  | atio           | 2 Accident investigation   |  | M 1 ☐ Yes   | s 2□No  |   |                                 |  |  |  |
| I or Attending Physical Control of after death. Director: After this in by the funeral di  | Certification: | determined 200. Flace C  | of injury - At home, farm, st<br>g, etc. (Specify) | treet, factory, office  |   | 28f. Location (St<br>City or Town           | reet and Number<br>n, State)    | or Rural Route Number,                           |  |  |
| DIVISION OF  To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di  | ical Ce        | 29a. Certifier  (Check only one)  1  Certifying Physician: To the to the control of the control one)   | sis of examination and/or i                        |   |   |   |                                 |  |  |  |
| o the ithin 2 o the o the omplet   | Medical        | 29h Signature and title of certifiers  |  | 29c. License n  | umber   | 2   | 9d. Date signed                 | (Month, Day, Year)                               |  |  |
| F 3 F 8  |                | ) OSCIP-   | M.D  | ח ת   | 055171  |   | 05/2                            | 7108.  |  |  |
| 10   |                | 30. Name and address of person who completed cause   | of death (Item 23a) (Type                          |   |   |   |                                 |  |  |  |
|  |                | Dr. Sebastian John, A  |  | - P   | venue   | Baltimo                                     | ore, MD                         | 21224  |  |  |
| Regi   | State          | 31. Date filed (Month Pay, 29ar) 2008 32.00  | gistrar's Signature                                | certi   |   |   |                                 |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19a per inf 8879 5-30-08 vt.
State of Maryland 7 Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Elmer C. Beavers 4:55 PM 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montagmery Montgomery Olney General Hospita If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral M** 2□ F Months Days Hours Min. 142-16-8737 87 Director 5/7/1921 New Jersey Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, If the Medical Examiner must be notified at appear. 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location 1 ☐ Yes 2 No **Funeral Director** MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3231 Ludham Drive 20906 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Mes 2 □ No If Yes, Give Year or Dates: Www. 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Completed by Specify. 3 Widowed 4 □ Divorced MWITT White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Telephone 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elmer Beavers Florence Vliet ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) **Darci** Pickering-daughter 14219 Ansted Rd. Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 5/27/2008 Beltsville, MD 22. Name and Address of Facility 21. Signature of Funeral Service Style & Jolimann Rapp Funeral and Cremation Svcs. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the cause of the death of the cause of the death of the cause of the death of the cause of the death of t Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dualto (or as a consequence of): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Muocardial Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 s autopsy performed After this certificate he funeral director, page 1 □Yes 2 No 1 ☐ Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No t'☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation within 24 hours after control to the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Bichhuon 4996 30. Name and address of porson who completed cause of death (Item 23a) (Type, Print)

Richmong M. Pinh 18101 Prince Philip Vive MO , Olney linh Bichhuong 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

DHMH 17 Rev 1/2001

Beavers

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Dav **Physician** 6:30 PM M Albert L. Begeman Jr. 2008 May 21, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1536 Tanyard Hill Rd. Gaithersburg Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 MM 2 □ F 51 Director 08/02/1956 214-52-3852 TN Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10b. County 10d. Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Gaithersburg Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 2 any injury or other traumatic event, the Medical Examiner must be no once. 20879-United States 1536 Tanyard Hill Rd. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Utility Company Elementary/Secondary (0-12) College (1-4or 5+) Class I Mechanic 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert L. Begeman Sr. Dorothy Petty 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan K. Begeman/Wife 1536 Tanyard Hill Rd. Gaithersburg, MD 20879-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State May 24 1 ☐ Burial 2 MacCremation 3 ☐ Removal from State Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M00382 Rapp Funeral & Cremation Serving 933 Gist Ave. Silver Spring, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Rapp Funeral & Cremation Services 933 Gist Ave. Silver Spring, Maryland 20910-Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RENAL FAILURE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner A bus be executed HEPATITIS Due to (or as a consequence of): attending physician Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 No Completed funeral director, page 2 should 24a. Was an autopsy performed? 1□ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 2 Accident Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D52000 MAY 22. 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registra

ERIC

31. Date filed (Month, Day, Year)

POLLACK

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M.D.

32 Registrar's Signature

**ORIGINAL** 

10215 FERNWOOD RD 404

BETHESDA MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2 Day 2000p 1:50 AM Physician Amelia Barrow Evelvn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Carroll Sykesville Copper Ridge Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ☐ M 21 F 88 579-40-0857 Dec 11 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be retified at once. 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 ☐ Yes 2 ☐ No MD Sykesville Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 605 Shimmering Run Court by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ▼□ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) health care Elementary/Secondary (0-12) College (1-4or 5+) registered nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Amelia Hughes Arthur H. Kirk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 605 Shimmering Run Ct., Sykesville, MD 21784 Daniel A. Barrow (son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National 8-19-08 Arlington, VA 21. Signature of Funeral Service License 22. Name and Address of FacilityHaight Funeral Home & Chapel Dauge spaight steribert P.O. Box 195 Sykesville, MD 21784 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Division of Vital Records, P.O. Box 68760, attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day 5 Other (specify) ed by the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed ģ 2 No 3 Probably 4 Unknown isease Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has 1 ☐ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To After this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral! 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

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Registrar

State

i berts

Road Cldersburg MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Miamian

MAY 28

31. Date filed (Month, Day, Year)

1645

32 Registrar's Signature

OB-03815 A BERRY P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 17136 State of Maryland / Department of Health and Mental Hygiene UNK UNK Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day May 19, 2008 0636 hrs Medical Examiner Shirley A.

4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** 100 Block Park Avenue If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** oreign Country) Months Days Hours DC Director 05 213-54-3228 Yrs 1 M 2 X F 57 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1 X Yes 2 No Parkville or items 23a or 28a-f show must be notified at once. Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21234 2509 Taylor Ave 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces' 1 Never Married 2 Married Yes X No Black Specify: 1 Yes 2 X No specify: f Yes. Give Year 3 Widowed 4X Divorced Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", , or other traumatic event, the Medical Examiner ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed College (1-4 or 5+) Elementary/Secondary (0-12) Private Agency 21215-0036 Nurse 4yrs 12th grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Florin Fullard Willie Lee Stackhouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2509 Taylor Ave, Parkville, Md 21234 MD Stephanie Logan-Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Woodlawn, Md 5/29/08 Department of Important: I Memorial Park King 4 Donation 5 Other Specify: March F/H West 21. Signature of Funeral Service License 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician failure. List only one cause on each line. Medical a Cardiomegaly complicated by bronchitis & bronchopneumonia Immediate Cause (Final disease ¬xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Division of Vital Records, P.O. Box 68760, 14 hours alor death certificate be executed a to the death certificate be executed to the safer death.

Financial Director: After this certificate has been signed by the attending physician and tetely filled in by the funeral director, page 2 should be detached for use as the burial - transit #1 as noted, 23a,27,perME,g881 7/17/08 TT Physician/Medical X AMENDED X UNPENDED 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 1 🗸 Yes No 26.Place of Death (Check only one 25. Was case referred to medical Be examiner? Nursing Home 5 Residence 6 ✔ Other: Scene Hospital: 1 Other<sub>4</sub> DOA Inpatient 2 ER/Outpatient 3 1 Yes 28c, Injury at Work? 28d, Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28h Time of Injury 27. Manner of Death 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the l within 2 To the 1 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 19, 2008 O.C.M.E. a ame and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 22, 7:59PM M V. David Barton May 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 X M 2 □ F Director 64 Nov. 15,1943 349-36-8947 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, I'm Mydical Exantine in ust by notified at 1 ☐ Yes 2X No Director MD Baltimore Owings Mills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9024 Groffs Mill Drive 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Ye ar or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Servant Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Vincent Barton Lorene Moore 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife 9024 Groffs Mill Drive, Owings Mills, MD Normalie Barton 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 5/24/08 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Hampstead, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10BLASTUMA Month 1 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) burial-transi be execut and Due to (or as a consequence of) 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 □ Yes 2 No
9 □ Unknown Month 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy After this certificate 2 🗆 No 1 □Yes 2 💆 No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) \( \text{VOSP} \) \( \text{Ce} \) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Hospital or Attending 124 hours after death. 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2008 pe, Print) Charles St Dowson NO 2/204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 M MUN 31. Date filed (Month, Day, Year) 32 Registrar's Signature MAY 2 8 Registrar DHMH 17 Rev 1/2001

ORIGINAL

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 17138 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 25, Physician 2008 Kathleen Violet Boam May 3:11pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dove House Hospice Westminster Carroll 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 02-5-1925 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 M 2 F Days 217-35-8502 83 England

10f. Zip Code

10d. Inside City Limits 1 □Yes 2 No

10g. Citizen of What Country?

10c. City, Town or Location

Reisterstown

**Funeral** Director

Usual Residence of Decedent

10e. Street and Number

10b. County

30. Name and address of perso, who completed cause of death (Item 23a) (Type, Print)

23 Crossroads Dr.

32. Bigistrar's Signature

Flavio Kruter M.D

31. Date filed (Month Pay, Year) 2 8 2008

Maryland Baltimore

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Evaniner must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Yuneral Director: After this certificate has been signed by the attending physician and completely filled in by the Innerial director, page 2 should be detached for use as the burial-transit

| ē                          | 300 Salony Drive   | Apt. 208  |                        | 21136   |                          | Un:                  | ited Stat                      | tes  |  |  |  |
|----------------------------|--|---|------------------------|---|--------------------------|----------------------|--------------------------------|--|--|--|--|
| ne                         | 11. Marital Status   | 12. Was Decedent Ever in U.S<br>Armed Forces?               | 3. 13. V               | Vas Decedent of Hispanic Original Yes, specify Cuban, Mexican,                                | gin? (Specify Yes or     | No-                  | 14. Race - Ame<br>Black, White |  |  |  |  |
| Y.                         | 1 ☐ Never Married 2 ☐ Married  | 1 □Yes 2 2 No<br>If Yes, Give                               |                        | ☐Yes 2XNo Specify:  | , r dorto r nodri, oto.) |                      |                                | White  |  |  |  |
| b<br>D                     | 3 XWidowed 4 ☐ Divorced  | Year or Dates:  |                        |   |                          |                      | Specify:                       | WIII CC  |  |  |  |
| olete                      | 15. Decedent's Educ<br>(Specify only highest grade                                 | cation<br>e completed)                                      | 16a. Deced             | ent's Usual Occupation<br>kind of work done during most<br>DO NOT use retired)                | of working               | 16b.                 | Kind of Business               | /Industry  |  |  |  |
| Completed by Funeral       | 9 years  | College (1-4or 5+)<br>n/a                                   |                        | emaker  |                          |                      | Own Home                       |  |  |  |  |
| BeC                        | 17. Father's Name (First, Middle, Last)  |   |                        | 18. Mother  | en Surname)              |                      |                                |  |  |  |  |
| 2                          | Joseph Miglorine   |   |                        | Maud  |                          |                      |                                |  |  |  |  |
|                            | 19a. Informant's Name/Relationship (Ty   | rpe. Print)   | 19b. Mailin            | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) |                          |                      |                                |  |  |  |  |
|                            | Maxwell Boam (Son)   | )   | 24 Be                  | llinger Ct. Re  | eisterstov               | vn, 1                | Maryland                       | 21136  |  |  |  |
|                            | 20a. Method of Disposition   | 20b. Pl   | ace of Dispos          | sition (Name of<br>natory or other place)   | Date                     | 20c.                 | Location - City or             | Town, State                                      |  |  |  |
|                            | 1 ☐ Burial 2 🖾 Cremation 3 ☐ R<br>4 ☐ Donation 5 ☐ Other (Specify)                 | removal mom state   |                        | emation Inc.5-  | -27-2008                 | Har                  | mpstead,                       | Maryland   |  |  |  |
|                            | 21. Signature of Funeral Service License   |   |                        | Name and Address of Facility  |                          |                      | -                              | ,  |  |  |  |
|                            | 136  | 581   | 1                      | 1824 Reisters   |                          |                      |                                | n, MD 21136                                      |  |  |  |
|                            | 23a. Part 1. Enter the disease, of compli<br>shock, or heart failure. List only or | ications that caused the death                              | . Do not ente          | er the mode of dying, such as   | cardiac or respirator    | arrest,              |                                | Approximate<br>Interval Between                  |  |  |  |
|                            | Immediate Cause (Final disease or condition  | GASTR   | 10                     | CANCET  | 2                        |                      |                                | Onset and Death                                  |  |  |  |
|                            | resulting in death)  | Due to (or as a consequ                                     | ence of):              |   |                          | 17 May               |                                |  |  |  |  |
|                            | Coguentially list conditions   | b   |                        |   |                          |                      |                                |  |  |  |  |
| ner                        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a consequ                                     | ence of):              |   |                          |                      |                                |  |  |  |  |
| am                         | that initiated events  | o   |                        |   |                          |                      |                                |  |  |  |  |
| Ĭ                          | resulting in death) Last   | Due to (or as a consequ                                     | ence of):              |   |                          |                      |                                |  |  |  |  |
| S                          |  | d   |                        |   |                          |                      |                                |  |  |  |  |
| N N                        | IF FEMALE:   |   |                        |   |                          |                      |                                |  |  |  |  |
| an/l                       | 23b. Was decedent pregnant 2   | 23c. If yes, outcome of pregnar<br>1 ☐ Live birth 2 ☐ Fetal |                        | Ectopic pregnancy   |                          |                      | 23d. Date of delivery          |  |  |  |  |
| SICI                       | in the past 12 months?<br>1 ☐ Yes 2 ☑ No   | 4 ☐ Pregnant at time of de                                  |                        | Other (specify)   |                          | _                    | Month Day Yea                  |  |  |  |  |
| Physician/Medical Examiner | 9 ☐ Unknown  |   |                        |   |                          |                      |                                |  |  |  |  |
| Š                          | Part II. Other significant conditions con  | ntributing to death but not resul                           | Iting in the un        | derlying cause given in Part I.   | 23e. Di                  |                      | _                              | o the cause of death?                            |  |  |  |
| Completed                  |  |   |                        |   | 1[                       | Yes                  | 2 No 3 P                       | robably 4 🗌 Unknown                              |  |  |  |
| <u>B</u>                   |  |   |                        |   | 24a. W                   | as an<br>itopsy      | 24b. Were au                   | utopsy findings available completion of cause of |  |  |  |
| Ę.                         |  |   |                        |   | pe<br>1 □ Ye             | rformed'             | death?                         | 2 No   |  |  |  |
| Be                         | 25. Was case referred to medical examiner?   |   |                        | 26. Place   | of Death (Check on       |                      | 10100                          |  |  |  |  |
| 0                          | 1 Yes 2 No   | Hospital: 1 ☐ Inpatient 2 ☐ E                               | ER/Outpatien           | t 3 ☐ DOA Other: 4 ☐ Nur  | rsing Home 5 Re          | esidence             | 6 dother (Spe                  | ecity DOVE HOUS                                  |  |  |  |
| ation:                     | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day, Year)                   | 28b. Time of<br>Injury | 28c. Injury at<br>Work?   |                          |                      | jury occurred                  | 7/   |  |  |  |
|                            |  |   |                        |   |                          |                      |                                |  |  |  |  |
| Ĭ                          | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                            | 28e. Place of Injury - At hor building, etc. (Specify       | ne, farm, stre         | et, factory, office   | 28f. Location            | (Street<br>Fown, Sta | and Number or R                | ural Route Number,                               |  |  |  |
| Medical Certific           |  |   |                        |   |                          |                      |                                |  |  |  |  |
| cal                        | Check only 2 Medical Exami   | slcian: To the best of my knowner: On the basis of examinat | vledge, death          | occurred at the time, date and  | d place, and due to t    | he cause             | e(s) and manner a              | s stated.  |  |  |  |
| ledi                       | Olle)  | and manner stated.  |                        |   |                          | , uate a             | and place, and due             | to the cause(s)                                  |  |  |  |
| 2                          | 29b. Signature and title of certifier  | to MA   |                        | 29c. License number   | ~ -                      | _                    | Date signed (Mont              |  |  |  |  |
|                            | Tolluo ku  | all root  |                        | 17 32 3   | 10                       | U                    | o - 27                         | -08  |  |  |  |

SE 340 Owngsmills, MD 21117

DHMH 17 Rev 1/2001

State Registrar

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| UO-U | .3003 |

Valerie D. Brown-Robinson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ADE OI  | Little Die   | ack inachaic iii. |              |                  |
|---------|--------------|-------------------|--------------|------------------|
| C+-+    | f Mandand    | Department of H   | l has dileat | Mental Hygiene   |
| VIOID O | t Marviano / | TROSUMENTOLE      | neallt and i | MCHILAI I IYANOH |

| 2        | 0 | 0 | 8 |   | 7   | 13  |
|----------|---|---|---|---|-----|-----|
| <u>_</u> | U | U | U | 1 | - / | 1 4 |

|   |                | For State  |                       |                     | •  |                              | Certific      | cate of       | Death                     |                   |                          |             |                     | Reg. No           | ).            | . 0 (         | , 0  | 1 / 10                     |
|---|----------------|--|-----------------------|---------------------|--|------------------------------|---------------|---------------|---------------------------|-------------------|--------------------------|-------------|---------------------|-------------------|---------------|---------------|--|----------------------------|
| Physicia  |                | egistrar<br>. Decedent's Name  | e (First, Midd        | e,Last)             |  |                              |               |               |                           |                   |                          |             | Date of De<br>Month | Day               | Year          |               | <ol> <li>Time of D</li> <li>1808 hr</li> </ol> |                            |
| edical Examin   | er             | VALERIE  | D. BR                 | OWN-                | -ROBIN   | SON                          |               |               |                           |                   |                          |             | May 20,             |                   | 1c. County o  | f Death       | 1000111  |                            |
|   | 4              | a. Facility Name (i  |                       |                     |  | ımber)                       |               | 4             | b. City, Tow<br>Suitland  |                   | cation of                | Death       |                     |                   | Prince G      |               | s  |                            |
|   |                | 3900 Suttlet to Note Apr. 104  |                       |                     |  |                              |               |               |                           |                   | 2/Hre                    | 8 Date of F |                     |                   | -             | nplace (State | or Foreign                                     |                            |
| Funeral   | 5              | . Social Security N  | lumber                | 6. Sex              |  |                              | i yrs. last b | orthday)      | Months                    | Days              | Hours                    | Min.        |                     |                   |               | Cou           | ntry)  |                            |
| Director  | -              | 579-84-  | 0798                  | 1_1                 | M 2 <b>X</b> F   | 46                           |               | Yrs.          |                           |                   |                          |             | 11-1                | 0-19              | 961           | DC            |  |                            |
|   | _              | Usual Residence of Decedent  10e State 10h County 10c. City, Town or Location  |                       |                     |  |                              |               |               |                           |                   |                          |             |                     | 10d. Inside       | City Limits   |               |  |                            |
| v any   | 1              | 0a. State  | 10b. County           |                     |  |                              |               |               | 511                       |                   |                          |             |                     |                   |               |               | 1 X Yes  | 2 No                       |
| Aaryland<br>28a-f show<br>d at once.  | ō L            | MD   |                       | E G                 | EORGE'   | S                            | SUIT          | LAND          | 405 75- 0                 |                   |                          |             |                     | 10a C             | itizen of Wh  | at Cour       | itry?  |                            |
| death with the Maryland<br>or items 23a or 28a-f sho<br>must be notified at once  | Director       | 10e. Street and Nu   | mber                  |                     |  |                              |               |               | 10f. Zip C                |                   |                          |             |                     | _                 | SA            |               |  |                            |
| the last  | اة             | 3966 SU  | ITLAND                | RO                  | AD #10   | 4                            |               |               |                           |                   |                          | .0./.0==    | -if . Van ar        |                   |               | - Ameri       | can Indian, E                                  | llack.                     |
| ms 2.   | uneral         | 1. Marital Status  1. Never Marri  |                       | 4                   | 12. Was De<br>Armed I  |                              | er in U.S.    | 13. Wa        | s Decedent<br>es, specify | ot Hisp<br>Cuban, | anic Ongii<br>Mexican, i | Puerto R    | Rican; etc.)        | 40-               |               | e, etc.       |  |                            |
| death<br>pr ite   | 됩              |  |                       |                     | 1 Yes  | 2 <b>X</b>                   | No            |               | Yes 2                     | 7 No              | on on the                |             |                     |                   | Specify:      | RT .          | ACK  |                            |
| after<br>'al",<br>iner  | ᆰ              | 3 Widowed  |                       |                     | If Yes, Give Ye<br>or Dates:   |                              | -4-d) 16      | ia. Deceden   | _                         |                   |                          | ind of wo   | ork done            | 161               | o. Kind of Bu |               |  |                            |
| 72 hours after<br>n "natural", c  | 힣              | 15. Decedent's E   |                       |                     |  | (1-4 or 5+)                  |               | during m      | ost of worki              | ng life. I        | DO NOT L                 | se retire   | ed)                 |                   |               |               |  |                            |
| n 72 lical I  | Completed      | Elementary/Sec<br>11th   | ondary (0-12          | ,                   | College  | (1 <del>-4</del> 01 5+)      |               | Custo         | odian                     |                   |                          |             |                     |                   | Priva         | ıte           |  |                            |
| 003<br>withing<br>jene.   | 틹              | 17. Father's Name  | /Eirot Middle         | a Lact)             |  |                              |               | 00300         |                           | 1                 | 8.Mother's               | Name (      | (First, Middl       | e, Maid           | en Surname    |               |  |                            |
| filed<br>I Hyged of   |                | unk  | (First, Middi         | s, Last,            |  |                              |               |               |                           |                   | G1                       | oria        | Brow                | n                 |               |               |  | _                          |
| 21215-0036  John be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at once. | o Be           | 19a. Informant's N   | lame/Relation         | ship (T             | /pe, Print )   |                              | - 1           | 19b. Mailin   | Address                   | (Street           | and Num                  | ber or R    | ural Route I        | Number            | , City or Tov | vn, State     | , Zip Code)                                    |                            |
| O 등 B is ig   |                | Owen Ro  |                       |                     |  | ıd                           |               | 3966          | Suit                      | Land              | Roa                      | d #1        | 04 S                | uit.              | land,         | MD            | 20746  |                            |
| re, ME<br>s 1 and 2 s<br>of Health au<br>If item 27   | ŀ              | 20a. Method of Di  | sposition             |                     |  |                              |               | ce of Dispos  | sition (Name              | e of cem          | netery,                  |             | Date                | 20                | Oc. Location  | - City or     | Town, State                                    | '                          |
| Nore, MD 2<br>ges I and 2 shoul<br>at of Health and N<br>i: If item 27 is n<br>other traumatic  |                |  | X Cremation           |                     | Removal  | from State                   | Met           | ropol         | itan (                    | lerm              | ator                     | v 05-       | -28-20              | 800               | Alex          | andr          | ia, V  | A                          |
| Baltimore,<br>permit. Pages I an<br>Department of He.<br>Important: If ite  |                | 4 Donation 21. Signature of F  | 5 Other               | Specify:            | see  |                              | Tice.         | 22.1          | Name and A                | Address           | of Facility              | MAR         | SHALL               | *S                | FUNER/        | L H           | OME OF   | MD                         |
| Baltimore, ME permit. Pages 1 and 2 s Department of Health a Important: If item 27 injury or other traum  | 2 /            | 2 Highadule of   |                       | Liouin              |  | ıld R                        | . Gra         |               |                           |                   |                          |             |                     |                   | land,         |               | 20746  |                            |
| Physician   | -              | 232 Par I. Enter   | the disease,          | or comp             | lications that   | caused th                    | e death. D    | o not enter   | the mode of               | dying,            | such as ca               | ardiac or   | respiratory         | arrest,           | shock, or he  | eart          |  | nate Interval<br>Onset and |
| Medical   |                | failure. List of   | nly to he caus        | se on ea            | ch line.<br>Athero   |                              |               |               |                           |                   |                          |             |                     |                   |               |               |  | Death                      |
| aminer  |                | Immediate Cause<br>or condition resul  |                       |                     | Due to (or as  |                              |               |               |                           |                   |                          |             |                     |                   |               |               |  |                            |
|   |                | Sequentially list of   | conditions            | b.                  |  |                              |               |               |                           |                   |                          |             |                     |                   |               |               | +  |                            |
|   | je.            | if any, leading to<br>cause. Enter Un  | immediate             |                     | Due to (or as  | s a conseq                   | uence of):    |               |                           |                   |                          |             |                     |                   |               |               |  |                            |
|   | Examiner       | (Disease or injury   | that initiated        | ٠. ا                | Due to (or a   | s a conseq                   | uence of):    |               | -                         |                   |                          |             |                     |                   |               | -             |  |                            |
| ecuted<br>and<br>transit  |                | events resulting i   | ii deatii) Las        | ď.                  |  |                              |               |               |                           |                   |                          |             |                     |                   |               |               |  |                            |
| execute<br>ian and  | Medical        | X UNPENDE  | .D                    |                     | AMENDE   | <br>Втт. 2                   | 7.ner         | ME . 08       | 81 7/                     | 10/0              | 77 8C                    | ,           |                     |                   |               |               |  |                            |
| 760,<br>icate be exe<br>physician a   | Med            | AMENDED   AMENDED   23a, PII, 27, perME, g881 7/10/08 TT   23d. Date of delivery   23d. Was decedent pregnant in the   23c. If yes, outcome of pregnancy   1 Live birth   2 Fetal death   3 Ectopic pregnancy   Month   Day   Year |                       |                     |  |                              |               |               |                           |                   |                          | Year        |                     |                   |               |               |  |                            |
| 387<br>rrtifica<br>ling p   | cian/l         | 23b. Was decede<br>past 12 mont  | nt pregnant ir<br>hs? | n the               |  | e birth                      | me of deat    |               |                           |                   | Ectopi                   | c pregna    | ancy                |                   | Month         |               | Day  | i cai                      |
| Box 687<br>e death certific<br>the attending p  |                | 1 Yes 2  | No 9 🗸 I              | Jnknowr             |  | known                        | ine or dear   | n 5 c         | Other (Spec               | city)             |                          |             |                     | - "               |               |               |  |                            |
| he the  | Phy            | Part II. Other sig   | nificant con          | ditions             |  |                              | but not res   | ulting in the | underlying                | cause             | given in P               | art I.      |                     |                   |               |               | o the cause                                    |                            |
| P.O.  | þ              |  | ol abu                |                     |  |                              |               |               |                           |                   |                          |             | 1 [                 | Yes               | 2 No          | 3 Pr          | obably 4                                       | Unknown                    |
| ords, P.O  w requires that sheen signed to  | ted            | MICOIN   | or aba                |                     |  |                              |               |               |                           |                   |                          |             |                     | Vas an            |               | . Were        | autopsy findi<br>completion                    | ngs available              |
| COTC<br>law re-<br>has be   | ple            |  |                       |                     |  |                              |               |               |                           |                   |                          |             | F                   | autopsy<br>erform | ed?           | death?        | ?  |                            |
| <b>Rec</b> The 1 cate 1 page  | Completed      |  |                       |                     |  |                              |               |               |                           | -0.5              | (D4)                     | (Ohaal      |                     | es 2              | No            | 1 🗸           | res  | 2 No                       |
| Division of Vital Records, pital or Attending Physician: The law requirents after death. After this certificate has been rifled in by the fineral director, page 2 should                               | Be (           | 25. Was case re examiner?  | ferred to med         |                     | Hospital:  |                              | [] -          |               | -                         | 26.Plac<br>00A    | Other                    |             | only one)           | R                 | esidence 6    | ✓ Ott         | ner: Scene                                     |                            |
| Vid<br>hysic<br>rthis   | <u>ء</u>       | 1 🗸 Yes  | 2 No                  |                     | ٠  | Inpatier                     |               | ER/Outpatie   |                           |                   | Jry at Wor               |             |                     |                   | w injury occ  |               |  |                            |
| n of<br>ling P  |                | 27, Manner of De   |                       |                     | 20a. D<br>(M   | ate of Injur<br>onth, Day,Ye |               | 200. Time 0   | 1 111,011 9               |                   | Yes 2                    | _           | 1                   |                   |               |               |  |                            |
| ttend<br>death<br>ctor:<br>y the  | ă              | 2 Accident   |                       | ending<br>vestiga   | tion   | Name of Init                 | At hor        | me, farm, st  | reet factor               |                   |                          |             | 28f, Local          | ion (St           | reet and Nu   | nber or       | Rural Route                                    | Number, City               |
| Division tal or Attendiins after death.   | Certification: | 3 Suicide  |                       | ould not            | l De   |                              | ury - At rior | ne, iaim, su  | reet, lactory             | , 0.11.00         | Danielli gj              | .,          |                     | wn, Sta           |               |               |  |                            |
| Hospital<br>24 hours<br>Funeral   |                | 4 Homicid  | e                     |                     | cian: To the   |                              |               | a dooth oss   | surrod at the             | e time r          | tate and n               | lace, an    | d due to the        | cause             | (s) and man   | ner as s      | tated.   |                            |
| Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,                      | Medical        | (Check only one)   | ✓ Medical E           | z Pnysic<br>Examine | er:On the ba   | sis of exan                  | nination an   | d/or investig | gation, in m              | y opinio          | n, death c               | ccurred     | at the time,        | date a            | nd place, an  | d due to      | the cause(s                                    | )                          |
| To the To the Company   | Med            | 29b. Signature a   |                       |                     | and mann   | er stated.                   |               |               |                           |                   | se numbe                 |             |                     |                   |               |               | Month, Day,                                    |                            |
|   | =              | 250.01910  | 1                     |                     | 1  | A-                           |               |               | - 1                       | O.C               | .M.E.                    |             |                     | - 1               | May 21,       | 2008          |  |                            |
|   |                | (al  | w                     |                     | Sometated.   | cauco of d                   | eath (Item    | 2301)         |                           | _                 |                          |             |                     |                   | -             |               |  |                            |
| 04  |                | 30. Name and a   |                       |                     | completed<br>sistant Me  |                              |               | 111 P         | enn Stre                  | et, Ba            | ltimore,                 | MD 2        | 1201                |                   |               |               |  |                            |
| V   | State          | 0.4 D 4 (1) d (4)  |                       | ear)                | 32   |                              | r's Signatu   | re            |                           |                   |                          |             |                     |                   |               |               |  |                            |
| Regi  |                | 4.   | 1AY 2 8               |                     |  | ENGLAS.                      | o St.         |               | de                        |                   |                          |             |                     |                   | no            | ME            |  |                            |
| DHMH 17 Rev 1   | 2001           |  |                       |                     | THE STATE OF THE S |                              |               | ORIGIN        | IAL                       |                   |                          |             |                     |                   | 00            | IME           |  |                            |

|   |   |                      | For<br>State<br>Registrar  | State of Mar   | ryland / Depa<br><i>Cei</i>  | artment of H<br>rtificate of I                             | lealth and M<br>Death                      | lental Hygid<br>Reg                     | ene<br>3. No. 2008   | 3 17140                                      |  |  |
|---|---|----------------------|--|--|--|--|--|---|--|--|--|--|
|   | Physicia  | an                   | 1. Decedent's Name (First, Middle, Last) Faye M. Blair   |  |  |  |  | Date of Death     Month                 | Day Year   | 3. Time of Death                             |  |  |
| ĭ   | /Medic  | al                   | 4a. Facility Name (If not institution, give str  | eet and number)  |  | 4b. City, Town, or   | Location of Death                          | May 27                                  | <b>2008</b> 4c. County of Dea                                | 4:10a <sup>M</sup>                           |  |  |
| <i>)</i>  | Examili   | ei                   | Crofton Convalesce   |  |  |  |  |   |  | Arundel                                      |  |  |
| k   | Funeral<br>Director   |                      | 5. Social Security Number 233–34–5407 6. Sex 1□ !  |  | (In yrs. last birthday)<br>5 Yrs.  | If Under 1 Year Months Days                                | Hours Min.                                 | 8. Date of Birth (Month, Day, 11/20/19  | 9. Bir<br>22   | thplace (State or Foreign ountry)  WV        |  |  |
|   | w w   |                      | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town or Lo  | cation   |  |   |  | 10d. Inside City Limits                      |  |  |
|   | Maryl<br>a-f sho<br>ified at  | ctor                 | MD Anne Arun   | de1  |  | Arnold   |  |   |  | 1 □Yes 2 □ No                                |  |  |
|   | with the<br>a or 28a  | Direc                | 10e. Street and Number<br>272 Waycross Way   |  |  | 10f. Zip Code  | 21012                                      | 100                                     | 10g. Citizen of What Country? USA                            |  |  |  |
| 9500  | be filed within 72 hours after death with the Maryland<br>ttal Hygiene.<br>cd other than "natural", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at | by Funeral Director  | 11. Marital Status  1 Never Married 2 Married  3C Widowed 4 Divorced   | . Was Decedent Ev<br>Armed Forces?<br>1  Yes  No<br>If Yes, Give<br>Year or Dates:                     |  | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes ※ No  | ispanic Origin? (Span, Mexican, Puerto     | ecify Yes or No-<br>Rican, etc.)        | 14. Race - Ame<br>Black, Whit<br>Specify: <b>Whi</b>         | te, etc.                                     |  |  |
| 712-0   | within 72 ho<br>iene.<br>than "naturi<br>the Medical E  | Completed            | 15. Decedent's Educa<br>(Specify only highest grade of<br>Elementary/Secondary (0-12)  |  | (Give  | DO NOT use retired   | during most of work<br>i)                  |   | 6b. Kind of Business   | ,  |  |  |
| and 21  | ould be filed w<br>Mental Hygier<br>arked other th  | Be                   | 12<br>17. Father's Name (First, Middle, Last)<br>William George  |  |  | Homemake   | er<br>18. Mother's Name<br><b>Arissa</b> 1 | e (First, Middle, Mi<br>Pharese         | Own Hon<br>aiden Surname)                                    | ne   |  |  |
| Maryi   | 2 sh<br>and<br>is m   | 오                    | 19a. Informant's Name/Relationship (Type<br>Linda L. Gilmer /  |  |  |  | and Number or Run                          |   | City or Town, State, 21012                                   | Zip Code)                                    |  |  |
| altimore,                                       | Pages 1 and 2 nent of Health int; if item 27 iny or other trains  |                      | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ Pere 4 ☐ Donation 5 ☐ Other (Specify)   | moval from State   | 20b. Place of Dispo<br>cemetery, cred<br>Lawnview                            | matory or other plac                                       | ce)  | Date 2                                  | Oc. Location - City or                                       |  |  |  |
| Balt  | permit. Pages<br>Department of<br>Important: If it<br>any injury or o   |                      | 21. Signature of Funeral Service Licensee  | C- Marsh   | 10-N 22  |  |  |   | ral Home I   | Inc.<br>MD 21230                             |  |  |
| be executed  Wedica Examined  purial-transit    |   | Examiner             | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any least of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to or as a   | consequence of):   | 1  | g, such as cardiac                         |   | St.  | Approximate Interval Between Onset and Death |  |  |
| sate cate the the                               | v requires that the death certifi<br>been signed by the attending<br>should be detached for use as  | by Physician/Medical | in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contri   | o. If yes, outcome p<br>1 □Live birth 2<br>4 □ Pregnant at ti<br>9 □ Unknown<br>ributing to death but  | ☐ Fetal death 3☐ ime of death 5☐ one of death 5☐ one of the sulting in the u | □Ectopic pregnancy □ Other (specify) □ nderlying cause giv |  | 23e. Did toba<br>1 ☐ Yes<br>24a. Was an | s 20 No 3 □ P  | o the cause of death?                        |  |  |
|   | sician: The law<br>certificate has b<br>rector, page 2 si   | Completed            |  |  |  |  |  | autopsy<br>perform                      | prior to   | completion of cause of                       |  |  |
| on or<br>ling Phys<br>After this<br>funeral dii | ing Phys<br>After this<br>funeral dii   | Certification: To Be | 25. Was case referred to medical examiner?  1  Yes  No Ho  27. Manner of Death   | spital:<br>1 ☐ Inpatien<br>28a. Date of Injury<br>(Month, Day<br>28e. Place of injur<br>building, etc. | Year) 28b. Time of Injury  | f 28c. Injur<br>Wor<br>M 1 □                               | er: 4 X Nursing Ho                         | 28d. Describe how                       | nce 6 Other (Spe<br>v injury occurred<br>eet and Number or F |  |  |  |
| בֿ  | To the Hospital or Attene within 24 hours after death To the Funeral Director; completely filled in by the  |                      | 29a. Certifier 1 ☐ Certifying Physi (Check only 2 ☐ Medical Examin   | cian: To the best of   | my knowledge, deat   |  |  | and due to the ca                       | use(s) and manner a  |  |  |  |
| )   | within 24  To the I  complete   | Medical              | 30. Name and address of person who com  31. Date filed (Month, Day, Year)  MAY 28 2008   |  |  |  |  |   |  |  |  |  |
|   | 4.  |                      | 30. Name and address of person who con Paul 13. Berez  | pleted cause of dea  | ath (lem 23a) (Type,<br>225 E  | Print) fens  | e Hwy,                                     | Croft                                   | on, mo   | 21114  |  |  |
|   | Sta<br>Registi  |                      | 31. Date filed (Month Day, Year) MAY 2 8 2008  | 3 Registrar  | 's Signature   | we   | ,  | 3.00                                    | <u> </u>   |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Amend 19a, perINF, g879 5/30/08 TT Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 22, 2008 8:15 A Ruth Ann Ball Barninger May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday **Funeral** Months Days Hours 1 □ M 2 🔀 F Aug. 4, 1955 Director 211-44-4447 52 Maryland Usual Residence of Decedent 10d. Inside Cify Limits 10a. State 10c. City, Town or Location 10b. County f Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Maryland Harford Bel Air 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2942 Nova Scotia Road 21015 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Farming 12 Farmer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Smith Ball Sr. Helen Louise Fitch ပ္ 19a Informant's Name/Relationship (Type. Print) Richard Barninger, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard S. Barninger Jr. 2942 Nova Scotia Rd., Bel Air, MD 21015 /Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of F
Important: If Ite
any Injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 5-28-08 4 □ Donation Towson, Maryland 5 ☐ Øther (Specify) 22 Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funer 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use in each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final me tustatic Surcome **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that in list and avents. Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in To the Hospital o within 24 hours aft To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certified 80 30. Name and address of person who completed cause of death (item 23a) (Type, Print) V m. D. 500 upper Chesapeake Dr. Bel Air, MD 21014 Bahrani,

DHMH 17 Rev 1/2001

State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 1105 **Physician** 08 Clyde Barlow /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner University of Mary and Medical Conte Saltimore 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min. **№** M 2□ F Hours Months Days July 29 1929 Louisanna 439-36-9574 78 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must but offited at 1 ☐ Yes 2X No Director Maryland Harford Darlington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene. 21034 USA 2232 Glen Cove Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 □XYes 2 □ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates: Specify 2 White 3€ Widowed 4 Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than \* College (1-4or 5+) Elementary/Secondary (0-12) Construction Truck Driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental em 27 is marked o Duncan Johnnie (unk) Barlow Sadie (unk) ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 98 Crothers Rd., Rising Sun, Maryland 21911 Lynn Marie Barlow-Melfa / Daughter Department of Health Important; If item 27 any Injury or other troone. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 5-30-08 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 (uss 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 3 day Physician neumonia /Medical Due to (or as a consequence of): EXAMINER Examiner vaumatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last MEDICAL Due to (or as a consequence of) Examine CENTECHTION MPPROVED BY Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, 🥸 and burial-trar Due to (or as a consequence of) physician Physician/Medical IUSON the attending por use as yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death Month in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 2 X No 1 ☐ Yes 2 No certificate 1 □Yes 25. Was case referred to medical examiner?

1 Yes 2 □ No 26. Place of Death (Check only one) Be ( Other: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 5 Pending investigation 1 Natural VNKNOWW 1 ☐ Yes 2 No tall after death. 21/2008 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined 4 ☐ Homicide 2232 Gun Cove Koad Home Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and disc to the cause (s) and manner as stated. e Funeral t 29a Certifier Medical | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Olsen, MD 204 Communit 31. Date filed (Month, Day, Year) Registrar's Signatur State MAY 28 2008 Registrar

|  |                | 1 - For<br>State<br>Registrar   | State of Marylan   | d / Depa<br><i>Cer</i>            | artment of H<br>tificate of L                 | ealth and N<br>Death                     |   | iene 0                            | 08 17143   |  |  |
|--|----------------|---|--|-----------------------------------|---|--|---|-----------------------------------|--|--|--|
| Physic   | ian            | 1. Decedent's Name (First, Middle, Las  |  |                                   |   |  | 2. Date of Deal<br>Month<br>5/23/20       |                                   |  |  |  |
| /Medi  |                | Charles Bodnar, S   |  |                                   |   |  |   |                                   |  |  |  |
| Exami  | ner            | 4a. Facility Name (If not institution, give<br>Baltimore Washing  |  | enter                             | Glen Bu                                       | Location of Death                        |   | 4c. County of Death  Anne Arunde1 |  |  |  |
| Funeral  | _              | 5. Social Security Number 6. Se   |  |                                   | Il Under 1 Year                               | If Under 24 Hrs.                         | 8. Date of Birth                          |                                   | 9. Birthplace (State or Foreign  |  |  |
| Director   |                | 215-16-0136   | <sup>M 2 □ F</sup> 85  | Yrs.                              | Months Days                                   | Hours Min.                               | 2/3/192                                   | 23                                | PA PA  |  |  |
| D .  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c Cit  | v. Town or Lo                     | cation  |  |   |                                   | 10d. Inside City Limits  |  |  |
| Aaryla<br>Fehor  | ŏ              | MD Anne Aru   |  | Severn                            | oation  |  |   |                                   | 1 ∐ Yes 25∰tNo   |  |  |
| 286-   | Director       | 10e. Street and Number  | inder  | Severn                            | 10f. Zip Code                                 |  | 1   | l 0g. Citizen of                  | What Country?  |  |  |
| death with the Maryland<br>ms 23e or 28e-f ehow<br>rmust be notified at  |                | 1401 Bittersweet  | Road   |                                   | 21144   |  |   | U.S.                              | .A.  |  |  |
| deati  | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in U<br>Armed Forces?  | .S. 13. V                         | Was Decedent of Hi<br>f Yes, specify Cuba     | ispanic Origin? (Sp                      | pecify Yes or No-                         |                                   | ice - American Indian,<br>ack, White, etc.                               |  |  |
| OU36<br>hours after<br>tural; or its   | by Fu          | 1 Never Married 2 Married   | X21Yes 2 ☐ No<br>If Yes, Give  |                                   | 1 □ Yes XXX No                                | Specify:                                 |   | Specia                            | rah i t o  |  |  |
|  |                | XXWidowed 4 ☐ Divorced  15. Decedent's Ed   | Year or Dates:   | 16a Deced                         | dent's Usual Occupa                           | ation                                    |   | 16h. Kind of B                    | Business/Industry  |  |  |
| within 72 ene.   | plet           | (Specify only highest grade Elementary/Secondary (0-12)   | de completed)  | (Give                             | kind of work done of<br>OO NOT use retired    | during most of world                     | king                                      | , ob. Time of e                   | racino de madery   |  |  |
| ild 212<br>filed with<br>Hygiene<br>other the  | Completed      | 6   | College (1-4or 5+)   | Truck                             | Driver  |  |   | Truck                             | king   |  |  |
| be filed half Hygied of other  | Be (           | 17. Father's Name (First, Middle, Last)   |  |                                   |   |  | ne (First, Middle,                        | Maiden Sumai                      | me)  |  |  |
| arylar<br>should by<br>ind Menta<br>in marked<br>umatic ev   | 2              | Wasyl Bodnar  |  | 100 1400                          |   | Anna H                                   |   | O'the Town                        | - Carte Tie Corde)   |  |  |
| 0 2 2 2  |                | 19a. Informant's Name/Relationship (7) Mr. Mark Stephen   |  |                                   | B Larch R                                     |  |   |                                   | n, State, Zip Code)  |  |  |
| re, IN Health tem 27 other tr  |                | 20a. Method of Disposition  |  | _                                 | sition (Name of<br>natory or other place      |  |   |                                   | - City or Town, State  |  |  |
| Baltimore, permit. Pages 1 a Department of Her importent: If Item any injury or oths   |                | 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify  | Hemovai from State   |                                   | iel's Cem                                     | 1 3                                      |   | Baltimo                           | ore. MD  |  |  |
| Dalti permit. Departm importe any inju   |                | 21. Signature of Funeral Service Cicer  |  |                                   | . Name and Addres                             |  |   |                                   | 1 & Cremation  |  |  |
| n ggesa  |                | fout ful  | M0141  | ll s                              | ervices                                       | 1 2                                      | nd Ave S                                  | SW; Gle                           | n Burnie, MD2106   |  |  |
|  |                | 23a. Part . Enter the disease, or comp<br>shock, or heart failure. List only                                | plications that caused the deat  |                                   |   | g, such as cardiac                       | or respiratory arr                        | est,                              | Approximate<br>Interval Between<br>Onset and Death                       |  |  |
| Physician  |                | Immediate Cause (Final disease or condition resulting in death)   | a Afrial '   |                                   | ah'on   |  |   |                                   | few minute   |  |  |
| /Medical<br>Examiner   |                | 1   | Due to (or as a conseq   | juence of):                       |   |  |   |                                   |  |  |  |
| **   | ĕ              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | b. Due to (or as a consec  | juence of):                       |   |  |   |                                   |  |  |  |
| ransit ansit   | Examine        | triat initiated events  | C  |                                   |   |  |   |                                   |  |  |  |
| 8 / 60 / cate be executed by sicion and the burial-tran  | X              | resulting in death) Last  | Due to (or as a consec   | (uence ol):                       |   |  |   |                                   |  |  |  |
| cate be executed physicien and the burial-transi   | dlcal          | •   | d  |                                   |   |  |   |                                   |  |  |  |
| Box 6  eath certific attending p   |                | IF FEMALE:  | 23c. If yes, outcome of pregna   | ancy                              |   |  | · · · · · · · · · · · · · · · · · · ·     | 23d D                             | ate of delivery  |  |  |
| death certifications of for use es   | clan           | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No  | 1☐Live birth 2☐Feta<br>4☐Pregnant at time of c   | ıl death 3 ☐                      | Ectopic pregnancy Other (specify)             |  |   |                                   | fonth Day Year   |  |  |
| at the class the | hys            | 9 Unknown   | 9⊡ Unknown   |                                   |   |  |   |                                   |  |  |  |
| - 25   | by Physician/M | Part II. Other significant conditions of  | ontributing to death but not res   | sulting in the un                 | nderlying cause giv                           | en in Part I.                            | 100000                                    | /                                 | ntribute to the cause of death?  |  |  |
| VITAL HECOTGS, ician: The law requires t certilicate hes been signe rector, page 2 should be   | fe             | Diaveres  |  | 1 3120                            | 11,0  | 1000                                     | 1 U Y                                     | es 22No                           | 3 Probably 4 □Unknown  |  |  |
| The law cate hes by page 2 st  | Completed      | hypolipidem   | a Word   | Posis                             | hyd   | so roph                                  | 24a. Was a autop:                         | sv                                | . Were autopsy lindings available prior to completion of cause of death? |  |  |
|  |                | outis dr.   | 8'ded  |                                   |   |  |   | 2 No                              | 1 Yes 2 No   |  |  |
| Of VItal Physician: rthis certifica  | o Be           | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatier                      | nt 3□ DOA Oth                                 | 00                                       | th <i>(Check only or</i><br>ome 5 ☐ Resid |                                   | thor (Specific)  |  |  |
| Phy<br>g Phy<br>er this  | H              | 27. Manner of Death   | 28a. Date of Injury  | 28b. Time of                      |   |  | 28d. Describe h                           |                                   |  |  |  |
| ath.   | ato            | 1 ☑Natural 5 ☐ Pending<br>2 ☐ Accident investigation  |  | Injury                            |   | Yes 2 □No                                |   |                                   |  |  |  |
| DIVISION OF  I or Attending Phy after death. Director: After this din by the funeral d   | Certification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Injury - At h<br>building, etc. (Speci                                   |                                   | eet, lactory, office                          |  | 28f. Location (S<br>City or Tow           | Street and Num<br>m, State)       | nber or Rural Route Number,  |  |  |
| Dital o  |                |   |  |                                   |   |  |   |                                   |  |  |  |
| DIVISION Of VITA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.   | Medical        | 29a. Certifier 1 Certifying Ph (Check only 2 Medical Exam   | ysician: To the best of my kno<br>niner: On the basis of examina<br>and manner stated. | owledge, deatl<br>ation and/or in | h occurred at the tir<br>vestigation, in my o | ne, date and place<br>pinion, death occu | , and due to the o<br>rred at the time, o | cause(s) and m<br>date and place  | nanner as stated.<br>, and due to the cause(s)                           |  |  |
| o the  | Me             | 29b. Signature and title of certifier,  | 2 0  |                                   | 29c. Licens                                   |  |   |                                   | ned (Month, Day, Year)   |  |  |
| F > F 0  |                | 124a Ch   | Attending Phr  | Kinga                             | 00  | 0788                                     | 73  | 5/2                               | 13/2008  |  |  |
| 10   |                | 30. Name and address of person who  | completed cause of death (Ite  | m 23a) (Type,                     | Print) Line                                   | DITAL                                    | NO 1                                      | 3400                              | 13/2008<br>BURNIE, MAL<br>23/2008  |  |  |
|  |                | AL Date filed (Month Day, Your)   | SELWAL, MY   | ,                                 | 3 17(0)                                       | /  | 7.,                                       | -)· (~                            | 2/06/  |  |  |
| St   | ate            | 31. Date filed (Month, Day, Year) NAY 2 8 20  | 08 Consistrar's sign   | K L                               | 2000 1  |  |   |                                   |  |  |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** acha Boone 2330 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NIA of tou Dance Boytomore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. **№** M 2□ F Director Usual Residence of Decedent death with the Maryland 10a State 10h County 10d. Inside City Limits 10c. City, Town or Location 28a-f show Injury or other traumatic event, I've Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country ŏ 30 or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 2 should be filed within 72 hours after on and Mental Hygiene. is marked other than "natural", or Itel 1 Never Married 2 Married 1 ☐Yes 2 ☐No Specify ģ 3 Widowed 4 Doivorced Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retiped) ANTOMOTICO Elementary/Secondary (0-12) College (1-4or 5+) hance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) DOORE ပ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traun Rd. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 30 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 23a. Pa 11 Entir the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shout, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (Mas a consequence o ): disease or condition resulting in death) /Medical Examiner o days multionaun Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner netastati burial-transi 60100 Due to (or as a consequence of): attending physician Physician/Medical the IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2 2 No 2 12 No 1 ☐ Yes □Ÿes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 KNo 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: within 24 hours after deatl To the Funeral Director:

3altimore, Maryland 21215-0036

心 N S S S S

State

29a. Certifier (Check only one)

30. Name and ad

29b. Signature and title of certifier

Satrolit

DHMH 17 Rev 1/2001

person who completed cause of death (Item 23a) (Type, Print)

ar's Signature

MD

2008 Regi

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in the properties of the control of the cause of t

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Baltimore,

29d. Date signed (Month, Day, Year)

2401 W. Bel under Ave.

22, 2008

Ber Winner

MD 2145

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TITM/8 per FH 0879 5/28/08 US State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAYDay 22, 2 108 Month **Physician** David B. Bryson 3:46A M /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Days 6. **Sey** 1⊞ M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 74 219-30-0943 Director 1934 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 □Yes 21 No Director Baltimore Sparks 10a. Citizen of What Country? 10e. Street and Number 10f. Zip Code ral", or Items 23a or Examiner must be r U.S.A. 15200 Priceville Rd. Completed by Funeral 21152 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married White 1 □ Yes ŽŽ No Baltimore, Maryland 21215-0036 "natural", or Specify Specify. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Artist Art permit. Pages 1 and 2 should be filed of Department of Health and Mental Hygis Important; If item 27 Is marked other any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Mary Salbierski ပ Roy William Bryson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 134 Golf Club Lane; Venice, Florida 34293-4110 Stephen Edwin Sanford / Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/24/08 4 □ Donation 5 □ Other (Specify) Baltimore, MD Metro Crematory Inc. 21. Signature Jun ral Septice Licensee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ASYSTOLE /Medical Due to (or as a consequence of): Examiner MYOCARDIAL INFARCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner be executed sician and burial-trans Due to (or as a consequence of) P.O. Box 68760, physician a Physician/Medical attending p for use as as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an cate has I page 2 s autopsy performed? Yes 2) No certificate 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA P 1 | Inpatient this After thi funeral 27. Manner of Death
1 XNatural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Iniury 1 ☐ Yes 2 ☐ No death. To the Funeral Director; completely filled in by the 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

OSLER DRIVE,

7601

32. Registrar's Signature

30. Name and address of person who complet cause of death (Item 23a) (Type, Print)

M. D. .

TABASSI

31. Date filed (Month, Day, Year)

D46356

TOWSON.

MARYLAND 21204

|                |  |                | 1 - State<br>Registrar   | State of   | Marylan   | d / Depa<br><i>Cei</i>         | artment<br>rtificate                              | of He                     | ealth a<br>Death                  | and Me                    | ental Hyg                                  | giene<br>Reg. No.        | 2008                                       | 17146  |
|----------------|--|----------------|--|--|---|--------------------------------|---|---------------------------|-----------------------------------|---------------------------|--|--------------------------|--|--|
| EA.            | Physicia<br>/Medic   |                | 1. Decedent's Name (First, Middle, Last) Elnora S. Bart  |  |   |                                |   |                           |                                   |                           | 2. Date of Dea<br>Month<br>May             |                          | Year<br>2008                               | 3. Time of Death                                   |
|                | Examin   | er             | 4a. Facility Name (If not institution, give s<br>Holy Cross Nursin   | g and I  | Rehab   |                                | Burt  | onsv.                     |                                   |                           |  | Mon                      | ounty of Death                             |  |
|                | Funeral<br>Director  |                | 5. Social Security Number 6. Sex 1076-01-6808  | M 2√xF   | 7. Age (In yrs. I   |                                | If Under<br>Months                                | 1 Year<br>Days            | If Under 2<br>Hours               | 24 Hrs.<br>Min.           | 8. Date of Birth<br>(Month, Day<br>April 1 | Year)<br>6,19            | 9. Birth<br>Cou<br>New                     | place (State or Foreign<br>ntry)<br>York           |
|                | e Maryland<br>a-f show<br>iffied at  | ctor           | 10a. State 10b. County  Maryland Howard  |  | 10c. City   | Colum                          |   |                           |                                   |                           |  |                          |  | 10d. Inside City Limits 1 ☐Yes 2X No               |
|                | h with the<br>23a or 28<br>st be not   | al Director    | 10e. Street and Number<br>6336 Cedar Lane  | Apt 20!  | 5   |                                | 10f. Zip  | Code 2104                 | 5                                 |                           |  |                          | n of What Cou                              | ntry?  |
| 5-0036         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene.  Important: If tier 27 is marked other than "natural", or Items 23a or 28a-f show important: If item 27 is marked other than "natural", or Items 25a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  | 12. Was Deced<br>Armed For<br>1 Tyes<br>If Yes, Give<br>Year or Da | 2 <b>⊠</b> No   |                                | Was Deced<br>If Yes, spec<br>1 ☐ Yes 2            |                           | panic Origin, Mexican<br>Specify: | gin? (Spec<br>i, Puerto F | cify Yes or No-<br>Rican, etc.)            |                          | Race - Ameri<br>Black, White<br>Decify: Wh |  |
| 0-61212        | l within 72 ho<br>piene.<br>r than "natur<br>the Medical   | Completed      | 15. Decedent's Edu<br>(Specify only highest grade<br>Elementary/Secondary (0-12)   | cation<br>e completed)<br>College (1-                              | 4or 5+)   | (Give<br>life.                 | dent's Usua<br>kind of wor<br>DO NOT us<br>SINESS | rk done di<br>se retired) | uring most                        | t of workin               | g  | 16b. Kind                | of Business/Id                             | ndustry  |
| yland          | ould be filed<br>Mental Hyg<br>arked other<br>atic event,  | To Be C        | 17. Father's Name (First, Middle, Last)  Vern R. Smith   |  |   |                                |   |                           |                                   |                           | (First, Middle,<br>Betsir                  |                          | ırname)                                    |  |
| Mar            | ind 2 sho<br>alth and<br>27 is ma<br>er traums   |                | 19a. Informant's Name/Relationship (Type Raymond Bartlett  | e. Print)<br>(Son)   |   |                                | -   |                           |                                   |                           | Route Number Colur                         |                          |  | •  |
| saitimore,     | Pages 1 a<br>ent of He<br>nt: If item<br>y or othe   |                | 20a. Method of Disposition  1 Burial 2 XCremation 3 R  4 Donation 5 Other (Specify)  | emoval from S  | nate  | Place of Disponentery, cre     |   |                           | 1                                 | 5-23-                     | ate<br>.2008                               |                          | tion - City or 1                           |  |
| Dalt           | permit. P<br>Departm<br>Importar<br>any injui  |                | 21. Signature of Funeral Service Lucens  | Home<br>Ls Ro  | -   |                                | a, MD 2   |                           |                                   |                           |  |                          |  |  |
|                | Physician<br>/Medical  |                | 23a. Part1. Enter the disease, or complishook, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)      | ne cause on ea   | used the death<br>ach line.   | h. Do not en                   |   |                           |                                   |                           |  | rest,                    |  | Approximate<br>Interval Between<br>Onset and Death |
| R/pg/s         | cate be executed  physician and the burial-fransit   | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Underlying that initiated events resulting in death) Last | Due to (   | or as a consequence as a consequence or a consequence or a | uence of):                     |   |                           |                                   |                           |  |                          |  |  |
| O. Box 68      | eath certifi<br>attending  <br>for use as  | Physician/Medi | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown  | 1 ☐Live bi   | come pf pregna<br>irth 2 □ Feta<br>ant at time of d<br>wn   | death 3                        | ⊒Ectopic pr<br>⊒ Other (sp                        |                           |                                   |                           |  | 23                       | d. Date of deli<br>Month                   | very<br>Day Year                                   |
| rds, P.        | w requires that the d<br>been signed by the<br>should be detached  | by             | Part II. Other significant conditions con  | ntributing to de   | ath but not res   | ulting in the u                | ınderlying c                                      | ause give                 | n in Part I.                      |                           | 23e. Did to                                |                          |  | the cause of death?                                |
| Vital Records, | The lar  | Completed      |  |  |   |                                |   |                           |                                   |                           | 24a. Was<br>autor<br>perfo<br>1 Yes        |                          |  | lopsy findings available ompletion of cause of     |
| on or Vita     | ding Phys<br><br>After this<br>funeral dir   | To Be          | 25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation                                     | ırsing Hor   | (Check only one 5 ☐ Reside the Period of th | dence 6                        |   | ify)                      |                                   |                           |  |                          |  |  |
| Division       | al or Attends all or Attends after deathal Director; all Director; ad in by the  | Certification: | Ž Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place<br>buildir  | of injury - At hong, etc. (Specif   | ome, farm, st                  | M  <br>reet, factory                              |                           |                                   |                           | 28f. Location (5<br>Cify or Tox            | Street and wn, State)    | Number or Ru                               | ral Route Number,                                  |
|                | To the Hospital or Ai within 24 hours after or To the Funeral Direct completely filled in by   | edical (       | 29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exami  | sician: To the<br>ner: On the ba<br>and mann                       | asis of examina   | owledge, dea<br>ation and/or i | th occurred<br>nvestigation                       | at the tim<br>, in my op  | ne, date ar<br>pinion, dea        | nd place, a               | and due to the<br>ed at the time,          | cause(s) a<br>date and p | nd manner as<br>lace, and due              | stated.<br>to the cause(s)                         |
|                | To the Mithin Comp   | Me             | 29b. Signature and title of certifier  | 2  |   |                                | 0   | o. License                | 45                                | 66                        |  | 6/2                      | signed (Mont)                              |  |
|                | Ý  |                | 30. Name and address of person who co  | VILL C   | e of death (Item  | n 23a) (Type                   | Print)  | inco                      | -11                               | 1-17                      | Silver                                     | spir                     | g mo                                       | 20902-   |
|                | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year) MAY 2 8 20   | 108 32.  | gistrar's Sign  | S: 4                           | boile   | ,                         |                                   |                           |  | 4                        | ,  |  |

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Rafael Alfonso Butron

2008 17117

|  |   | 1- For State<br>Registrar   | J   | Certif       | icate of        | Death                           |               | ,,,                | Reg. No                                 | <b>2,00</b>                     | 0 1/14                                    |  |
|--|---|---|---|--------------|-----------------|---------------------------------|---------------|--------------------|---|---------------------------------|---|--|
| Physicia<br>cal Examir   | an/   | Decedent's Name (First, Middle, Last     Rafa   |   | so But       | ron             |                                 |               | М                  | ate of Death<br>onth Day<br>ay 12, 2008 | Year                            | 3. Time of Death<br>0614 hrs              |  |
|  |   | 4a. Facility Name (if not institution, give<br>Shady Grove Adventist Ho   | e street and number)                          |              |                 | b. City, Town, or<br>Rockville  | Location of   |                    |   | c. County of Deat<br>Montgomery | <u> </u>                                  |  |
| Funeral  |   | Social Security Number 6. S |   | In yrs. last | birthday)       | If Under 1 Yea                  | r If Under    | 24Hrs. 8.1         | Date of Birth(MI                        | M/DD/YYYY) 9. Bir               | thplace (State or                         |  |
| Director   |   | unk. 1[X  | M 2 F   |              | Yrs.            | Months Day                      | s Hours       | Min. J.            | anuary 8                                | 3,2008 Forei                    | gn Maryland<br>ountry)                    |  |
| any  |   | Usual Residence of Decedent  10a. State  10b. County  | 10  | Oc. City, To | wn or Location  | on                              |               |                    | -                                       |                                 | 10d. Inside City Limits                   |  |
| nd<br>show a   | -   | Maryland Montgo   | mery  | Gai          | thersb          | urg                             |               |                    |   |                                 | 1 X Yes 2 No                              |  |
| larylar  | Director  | 10e. Street and Number  |   |              |                 | 10f. Zip Code                   |               |                    | 10g. C                                  | itizen of What Cou              | intry?                                    |  |
| with the Maryland<br>is 23a or 28a-f sh<br>e notified at once  |   | 814 West Side Dra   | ive   |              |                 | 2087                            | 78            |                    | Un                                      | ited Sta                        | tes                                       |  |
| death with the Maryland or items 23a or 28a-f show must be notified at once.   | Funeral   | 11. Marital Status  1 X Never Married 2 Married   | 12. Was Decedent Ev<br>Armed Forces?          | ver in U.S.  |                 | Decedent of His                 |               |                    |   | 14. Race - Ame<br>White, etc.   | rican Indian, Black,                      |  |
| or ite   | Fu  |   |   | No           |                 |                                 |               | Boliv              |   | Specify: B1                     | ack                                       |  |
| rs afte  | ģ   | Widowed 4 Divorced  15. Decedent's Education (Specify or  | or Dates:                                     | leted) 16    |                 | 's Usual Occupa                 |               |                    |   | . Kind of Business              |   |  |
| "nat   | Completed   | Elementary/Secondary (0-12)   | College (1-4 or 5+                            |              |                 | st of working life              |               |                    |   |                                 | ·   |  |
| 12 should be filed within 72 th and Mental Hygiene. 127 is marked other than "umatic event, the Medical and a management than "  | ηpl   | 0   |   |              | n               | / a                             |               |                    |   | n/a                             |   |  |
| permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.   |   | 17. Father's Name (First, Middle, Last)   |   | · · ·        |                 | Ī                               |               |                    | t, Middle, Maide                        |                                 |   |  |
| d be fi<br>fental<br>arked<br>went,  | o Be  | Pablo D. Butron   | Dist.   |              | 405 14-92       | Address (C:                     |               |                    | Johnso                                  | n<br>City or Town, Stat         | a Zin Cada)                               |  |
| shoul<br>and M<br>7 is m   | ۲   | 19a. Informant's Name/Relationship (T<br>Tiffany N. Johnson   |   | - 12         |                 | •                               |               |                    |   | irg, MD 2                       |   |  |
| and 2<br>lealth<br>tem 2<br>traun  |   | 20a. Method of Disposition  | ii / Hocher                                   |              |                 | tion (Name of ce                | metery.       | Dat                | e 200                                   | c. Location - City o            |   |  |
| Definition of the pages 1 are permit and pages 1 are permit of the permit in the principle of the permit of the pe |   | 1 X Burial 2 Cremation 3  |   | 7 I          | matory or oth   | <sub>er place)</sub><br>Cemeter | -37           | May 200            |   |                                 | Maruland                                  |  |
| it Pa<br>urtmen<br>ortant<br>ry or e   |   | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licen  |   | AII          |                 |                                 |               |                    |   |                                 | , Maryland                                |  |
| Depa<br>Impo   |   | Myletia Rain  | \ //  | 01305        | Rot             | West Mon                        | Pumph         | rey Fu<br>V Avenue | ineral H<br>Rockvi                      | łome/Rock<br>lle.Marvla         | ville, Inc.<br>and 20850-2805             |  |
| hysician   | (   | 23a. Part II Enter the disease, or comp   | lications that caused th                      |              | o not enter th  | e mode of dying                 | , such as ca  | rdiac or res       | piratory arrest, s                      | hock, or heart                  | Approximate Interval<br>Between Onset and |  |
| Medical<br>xaminer   |   | Mailure. List only one cause on ear Immediate Cause (Final disease a.   | Sudden une                                    | xplai        | ned de          | eath in                         | infan         | cy (SI             | DI)                                     |                                 | Death                                     |  |
| Adminier   |   |   | Due to (or as a conseq                        | uence of):   |                 |                                 |               |                    |   |                                 |   |  |
|  | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): |   |   |              |                 |                                 |               |                    |   |                                 |   |  |
|  | m<br>in   | cause. Enter Underlying Cause   |   |              |                 |                                 |               |                    |   |                                 |   |  |
| ed<br>nsit   | Examiner  | events resulting in death) Last   | Due to (or as a conseq                        | uence of):   |                 |                                 |               |                    |   |                                 | 14  |  |
| rou,<br>icate be executed<br>physician and<br>the burial - transit   | edical  | X UNPENDED  | AMENDED 23a,                                  | 27,28        | a-f, p          | erME, g                         | 881 7         | /29/08             | 3 TT                                    |                                 |   |  |
| cate be ex<br>physician  | <b>l</b> edi  | IF FEMALE:  | 23c. If yes, outcome                          |              |                 |                                 |               |                    |   | 23d. Date of delive             | l   |  |
| oof ou,<br>certificate be<br>ading physic<br>se as the buri  | an/M  | 23b. Was decedent pregnant in the past 12 months?   | 1 Live birth                                  |              | 2 Fet           | al death 3                      | Ectopic       | pregnancy          | }                                       | Month                           | Day Year                                  |  |
| death ce   | sici  | 1 Yes 2 No 9 Unknowr  | Pregnant at tir                               | me of death  | 5 Oth           | ner (Specify)                   |               |                    |   |                                 |   |  |
| the de   | Physician   | Part II. Other significant conditions   |   | but not resu | ulting in the u | nderlying cause                 | given in Par  | rt I.              | 23e. Did tobaco                         | co use contribute t             | o the cause of death?                     |  |
| gned by  | by  |   | -   |              |                 |                                 |               | 1                  | 1 Yes 2                                 | No 3 Pr                         | obably 4 🗹 Unknown                        |  |
| The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | Completed   |   |   |              |                 |                                 |               | _                  | 24a. Was an                             |                                 | autopsy findings available                |  |
| 2 E 2  | d<br>m  |   |   |              |                 |                                 | <u> </u>      |                    | autopsy<br>performed                    | ? death?                        |   |  |
|  |   | 25. Was case referred to medical  |   | _            |                 | 26.Plac                         | e of Death (  | Check only         | 1 Yes 2                                 | No 1 🗸                          | res 2 No                                  |  |
| Hospital or Attending Physician:<br>44 hours after death.<br>Funeral Director: After this certified filled in by the funeral director,   | o Be  |   | Hospital: 1 Inpatient                         | t 2 🗸 EI     | R/Outpatient    |                                 | I Others      | Nursing Ho         |   | idence 6 Oth                    | er:                                       |  |
| fing Phy<br>After th<br>funeral of   |   | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day,Yea        | / 2          | 8b. Time of Ir  | jury 28c. Inji                  | ury at Work?  | ? 28d              | . Describe how                          | injury occurred                 |   |  |
| eath.<br>For: A  | ţi  | 1 Natural 5 Pending   | 5/12/09                                       |              |                 | i 1                             | Yes 2 X       | .No                | ık                                      |                                 |   |  |
| tal or Attendiirs after death.  al Director: Aled in by the fu   | ifica   | 2 Accident Investigati 3 Suicide 6 X Could not  |   |              |                 |                                 | building, etc |                    |   |                                 | Rural Route Number, City                  |  |
| ospital or Attenct<br>hours after death<br>meral Director:<br>y filled in by the   | Certification:  | 4 Homicide determine  |   | ınd at       | resid           | lence                           |               | 814                |   |                                 | Gaithersburg                              |  |
| Hos<br>24 h<br>Fun<br>stely  |   | ,-,   | ian: To the best of my                        |              |                 |                                 |               |                    |   |                                 |   |  |
| - 0 <u>-</u>   | Medical   |   | r:On the basis of exami<br>and manner stated. | iliation and | or investigat   |                                 |               | Lunea at the       |   |                                 |   |  |
| To the within To the comple  | _   | 29b. Signature and title of certifier   |   |              |                 |                                 | se number     | OCN                | 15                                      | d. Date signed (M               | ioniii, Day, rear)                        |  |
| To the Hospital or A within 24 hours after or To the Fineral Direc completely filled in by   | Σ   |   | 11.   |              |                 | 1 00                            | N/I -         |                    |   |                                 |   |  |
| To the within To the comple  | Z   | Theodor M.  | King The                                      | in           | P               | 0.0                             | .M.E.         |                    | IV                                      | lay 13, 2008                    |   |  |
| To the within To the comple  | M   | 30. Name and address of person who<br>Theodore M. King, Jr., MD   | - 11  |              |                 | 111 Penn S                      |               |                    |   |                                 |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year May 24, **Physician** 2008 22:55 Peter John Bonita, Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 9, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 X M 2 □ F Jan. 067-14-9024 85 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natura!" --- any injury or other traumatic events. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1X Yes 2 No Maryland | Montgomery Director Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 1911 Valley Stream Drive 20851 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ⊠Yes 2 □ No Black, White, etc. 1 Mayes 2 No
If Yes, Give
Year or Dates: 1943-62 1 ☐ Never Married 2 N Married 1 ☐Yes 2 🎇 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Topographer Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosa Constantino Luigi Bonito ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1911 Valley Stream Drive, Rockville, MD 20851 Mitsu O. Bonita / Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery June 5, 2008 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M00896 300 W. Montgomery Ave., Rockville, MD 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Cie Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) ☐Yes 2☐No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy certificate 2 No 1 ☐ Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 N ပ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 No 2 Accident Director: 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. Name and address of person who completed cause of death (Item 23a) (Vpe, Print) WANN ecroescur Ro

Registrar

31. Date filed (Month, Day,

egistrar's Signature

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Carver orence MAL 27 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner ASSISTED Li If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Social Security Number **Funeral** Days Months Hours 1 ☐ M 2 💢 F 212-22-7703 83 Director 02-28-1925 MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show t be notified at 10a. State 10b. County 1 ☐ Yes 2X No MD Harford Bel Air Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA items 23a 701 HIgh Plain Drive 21014 r than "natural", or items 23a the Medical Examiner must I Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates: 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Legal Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Margaret Busch William E. Jeffries, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 701 HIgh Plain Drive Bel Air, MD 21014 William Carver (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Highview Mem. Gar. 06-02-2008 Fallston, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Marie Inc. 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final disease or condition resulting in death) obstructive 20 Years Pulmonary **Physician** Chronic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the bunal-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: NIA 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Parkinson's 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ★ No 24a. Was an page 2 s autopsy 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 to ther (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After this safter death.
Loirector; After this d in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and phanner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of certifier M.D.D56531 30. Name and address of person who completed cause of death (item 23a) (Type, Print) Harry Li, 8600 Snewden River Pkwy #30), columbia, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Monthay Day 2008 11:30F M Physician orothy Hnn /Medical 4b. City, Town, or Location of Death 4c. County of Death i ⊞ □ r € 4a. Facility Name (If not institution, give street and number) **Examiner** Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🖾 F Yrs. 71-18-9536 21. Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be multiped at 1 ☐ Yes 2 No Director  $\mathcal{M}_{\mathcal{L}}$ altimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 234 21 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates Specify þ White 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County College (1-4or 5+) Elementary/Secondary (0-12) School permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; if item 27 is marked other the any injury or other traumatic event, the once. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Kenneth Avenue hambe Hrdmore 20b. Place of Disposition (Name of cemetery, crematory or other place)
Euans Funeral Chapel
& Cremation Services Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 23/2008 torest Hill 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

The second chapel of Cremation 21. Signature of Funeral Service Licensee Evans Funeral Cha 8800 Harford Road 21234 Parkville 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PULMONARY EDEMA **Physician** /Medical Due to (or as a consequence of) CONGESTIVE HEART FAILURE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or): Examine Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 Other (specify) ed by the a detached for signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No certificate Nο Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

5

MAY 28 2008

31. Date filed (Month, Day, Year)

KHOSROW TABASSI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title 9

OSLER DRIVE TOWSON MARYLAND M. D 7601 32. Registrar's Signatur

29c. License number

46356

29d. Date signed (Month, Day, Year)

|                |   |                | For<br>State<br>Registrar                                      |                               | State c                     | of Ma              | aryland             |                     | artmen<br>ertificat                     |                   |                         | and M        | ental l                     | Hygid<br>Red                | ene 2               | 008                              | 1715                               | 51  |
|----------------|---|----------------|--|-------------------------------|-----------------------------|--------------------|---------------------|---------------------|---|-------------------|-------------------------|--------------|-----------------------------|-----------------------------|---------------------|----------------------------------|------------------------------------|-----|
|                | 2   |                | Decedent's Name (First, Midd                                   | le, Last)                     |                             |                    |                     |                     |   |                   |                         |              | 2. Date o                   | f Death                     | Day                 | Year                             | 3. Time of Death                   | 1   |
|                | Physicia<br>/Medic  |                | Joseph Jaco  | b C                           | itrand                      | )                  |                     |                     |   |                   |                         |              | May                         | 23                          | 20                  |                                  | 12:10a                             | М   |
| )              | Examin  |                | 4a. Facility Name (If not institution                          | -                             |                             | mber)              |                     |                     |   |                   | Location                | of Death     | -                           |                             |                     | nty of Death                     |                                    |     |
| XX.            |   | 7              | Holy Cross Ho 5. Social Security Number                        | Spita<br>6. Sex               |                             | 7 400              | - (In In            | at hirthday         | -                                       | •                 | pring<br>   If Under    | 24 Hrs       | 9 Date o                    | f Rirth                     | 1                   | tgomen                           | olace (State or Fore               | ian |
|                | Funeral<br>Director   |                | 217 <b>-</b> 14-9441   |                               | M 2□F                       | 82                 | e (In yrs. la       | Yrs.                | Months                                  |                   | Hours                   | Min.         | 8. Date o<br>(Month<br>June |                             |                     | MD                               | ntry)                              | gri |
| h              |   |                | Usual Residence of Decedent                                    | Λ                             |                             | 02                 |                     |                     |   |                   |                         | <u> </u>     | Julie                       | 10                          | 1923                | 1 3                              |                                    |     |
|                | irylan<br>ihow  |                | MD 10b. Count Howar  |                               |                             |                    | 10c. City,<br>G1env | Town or L           | ocation.                                |                   |                         |              |                             |                             |                     |                                  | 10d. Inside City Lim<br>1 ∐Yes 2X1 |     |
|                | Ba-f s  | Director       |  | u<br>———                      |                             |                    | Grenv               | voou                | 1.04 ===                                |                   |                         |              |                             | 10                          | - 011               | 114/b-1-0                        |                                    |     |
|                | a or 2  | D.             | 10e. Street and Number 3295 Kenallen                           | Court                         | t.                          |                    |                     |                     | 10f. Zip                                | 738               |                         |              |                             |                             | g. Cilizen d<br>USA | of What Cou                      | nury?                              |     |
|                | ns 23   | Funeral        | 11. Marital Status   |                               | 2. Was Dec                  |                    | Ever in U.S         | . 13                | . Was Dece                              | dent of H         | ispanic Ori             | igin? (Spe   | cify Yes o                  | r No-                       | 14. R               | ace - Ameri                      |                                    |     |
| ٥              | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at |                | 1 Never Married 2 Ma   | rried                         | Armed For 1 V Yes If Yes, G |                    | o WW]               | II                  | If Yes, spe<br>1 ☐ Yes                  | 1                 | an, Mexicar<br>Specify: | n, Puerto I  | Rican, etc.                 | .)                          |                     | lack, White,                     |                                    |     |
| 5-0036         | iours<br>iral",   | d b            | 3 X Widowed 4 ☐ Divorce  | d                             | Year or E                   | ates:              |                     |                     |   | **                |                         |              |                             |                             |                     | cify:whit                        |                                    |     |
| Š              | "natu   | Completed      | 15. Decede<br>(Specify only high                               | nt's Educa<br>est grade       | ation<br>completed)         |                    |                     | (Giv                | edent's Usu<br>e kind of wo<br>DO NOT u | rk done d         | durina mos              | st of workin | ng                          | Ī                           |                     | Business/Ir                      | *                                  |     |
| 7              | filed within<br>Hygiene.<br>Ither than "  | d mo           | Elementary/Secondary (0-12)                                    |                               | College (                   | 1-4or 5            | +)                  | _                   | bing 8                                  |                   | ,                       | cont         | ract                        | or ]                        | plumb:              | ing &                            | heating                            |     |
| 0              | other<br>other  | BeC            | 17. Father's Name (First, Middle                               | , Last)                       |                             |                    |                     |                     |   |                   |                         |              |                             |                             | aiden Surn          | ame)                             |                                    |     |
| /land          | uld be<br>Mental<br>Irked o   | 10             | Samuel Citrano   |                               |                             |                    |                     |                     |   |                   | Marg                    | aret         | Guto                        | wssl                        | κi                  |                                  |                                    |     |
| lar            | 2 should to and Men's is marked raumatic  |                | 19a. Informant's Name/Relation                                 |                               |                             |                    |                     |                     | _                                       |                   |                         |              |                             |                             |                     | ın, State, Zi                    | o Code)                            |     |
| ≥<br>″         | l and lealth  |                | Pat Hopkins (d   | augn                          | ter)                        |                    | 20h Bir             |                     | Kena.                                   |                   |                         |              | 1WOOd                       |                             |                     | 38<br>n - City or T              | own Ctata                          |     |
| saltimore,     | it of F<br>If ite<br>or ot  |                | 20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation            |                               | moval from                  | State              |                     |                     | oosition (Na<br>ematory or              |                   |                         |              |                             |                             |                     | -                                |                                    |     |
|                | urtmer<br>urtant:<br>urtant:<br>njury   |                | 4 ☐ Donation 5 ☐ Other (                                       |                               | ۵                           |                    | Cres                |                     | wn Mer<br>22 Name a                     |                   |                         | 5-28-        |                             |                             |                     |                                  | le, MD<br>Chapel                   | _   |
| g              | permit. Pages 1<br>Department of H<br>Important: If ite<br>any Injury or ot<br>once.  |                | ▶ Parce spain  |                               |                             | ut-                |                     |                     | .O. Bo                                  |                   |                         |              |                             |                             |                     |                                  | Chaper                             |     |
| Г              |   |                | 23a. Part1. Enter the disease, of shock, or heart failure. Lis | or complic                    | ations that                 | caused<br>each lir | the death.          | Do not e            | nter the mo                             | le of dyir        | ng, such as             | cardiac o    | or respirato                | ory arre                    | st,                 |                                  | Approximate<br>Interval Between    | =   |
|                | Physician   |                | Immediate Cause (Final disease or condition                    |                               |                             |                    |                     | ch                  | alk                                     |                   |                         |              |                             |                             |                     |                                  | Onset and Death                    |     |
| h              | /Medical  |                | resulting in death)  | Ca.                           | Due to                      | (or as             | a conseque          | ence of):           | CCIC                                    |                   |                         |              |                             |                             |                     |                                  |                                    |     |
|                | Examiner  | Ļ              | Sequentially list conditions, if any, leading to immediate     | , b.                          | Duete                       |                    | a conseque          |                     |   |                   |                         |              |                             | _                           |                     |                                  |                                    |     |
|                | ₫ W Œ   | Examine        | Cause. Enter Underlying<br>Cause (Disease or injury            | <b>~</b>                      | Due to                      | (or as             | a conseque          | erice oi).          |   |                   |                         |              |                             |                             |                     |                                  |                                    |     |
| ,              | execu<br>l and  | xar            | that initiated events resulting in death) Last                 | c.                            | Due to                      | (or as             | a conseque          | ence of):           |   | <del> </del>      |                         |              |                             |                             |                     |                                  |                                    |     |
| 9/90           | certificate be executed ding physician and see as the burial-transit  | dical          |  | d.                            |                             |                    |                     |                     |   |                   |                         |              |                             |                             |                     |                                  |                                    |     |
| Ŏ              | rtifica<br>ng ph<br>as th   | Medi           | IF FEMALE:   | 1                             |                             | -                  |                     |                     |   |                   |                         |              |                             |                             | 1                   |                                  |                                    |     |
| X<br>R<br>R    | leath certifica<br>attending ph<br>I for use as th  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?              | 23                            |                             | birth              | 2 Fetal             | death 3             | □Ectopic p                              |                   | /                       |              |                             |                             |                     | Date of deliv                    | rery<br>Day Year                   |     |
| -<br>-         | the death<br>y the atten<br>iched for u   | ysic           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                                  |                               | 4∐Preg<br>9□Unkr            |                    | time of de          | ath 5               | Other (s                                | oecity)           |                         |              |                             | _                           |                     |                                  |                                    |     |
| 7.             | w requires that the debeen signed by the should be detached   |                | Part II. Other significant condi                               | ions con                      | tributing to                | teath bu           | ut not resul        | Iting in the        | underlying o                            | ause giv          | en in Part I            | l.           | 23e.                        | Did tob                     | acco use co         | ontribute to                     | the cause of death?                |     |
| g              | requires that<br>een signed b<br>nould be deta  | d b            | Chronic obs  | me                            | tive                        | 0                  | ulm                 | one                 | ing                                     | dis.              | eas.                    | e            |                             | 1 🔲 Ye                      | s 2 No              | 3 □ Pro                          | bably 4 Unkno                      | wn  |
| Ö<br>Ö         | law rec<br>as bee<br>2 shou   | Completed by   |  |                               |                             | 1                  |                     |                     | i                                       | _                 |                         |              |                             | Was an                      | 24                  | b. Were aut                      | opsy findings availa               | ble |
| Ĭ              | The law<br>cate has b<br>page 2 st  | mo             |  |                               |                             |                    |                     |                     |   |                   |                         | ,            | 1 <sub>D</sub> Y            | autopsy<br>perform<br>'es 2 | ed?                 | prior to co<br>death?<br>1 ☐ Yes | ompletion of cause of<br>2.☑√No    | ΤC  |
| Vital Records, | ysician: The lar<br>iis certificate has<br>director, page 2   | Be C           | 25. Was case referred to medic examiner?                       | -                             |                             |                    |                     |                     |   |                   | 26. Place               | e of Death   | (Check o                    |                             |                     |                                  | -                                  |     |
| <u>o</u>       | di is   | 2              | 1 ☐ Yes 2 ☐ NO   | H                             | ,                           | Hipatie            |                     |                     | ent 3 □ Do                              |                   | 4 L N                   |              |                             |                             |                     | Other (Spec                      | ify)                               |     |
|                | tending Physeath. tor After this the funeral di   | ion:           | 27. Manner of Death 1 ■ Natural 5 □ Pend                       | ing                           | 28a. Date<br>(Moi           | of Inju            |                     | 28b. Time<br>Injury | of M                                    | 28c. Injur<br>Wor | yat<br>k?<br>Yes 2.⊟    |              | 28d. Desc                   | ribe ho                     | w injury occ        | curred                           |                                    |     |
| UINISION       | Atter ding<br>r death.<br>ector After<br>by the fune  | ficat          | 3 ☐ Suicide 6 ☐ Could  | tigation<br>I not be<br>mined | 28e. Plac                   | e of inju          | ury - At hor        | ne, farm, s         | treet, factor                           |                   | 163 2                   |              | 28f. Locati                 | ion (Str                    | eet and Nu          | mber or Rui                      | al Route Number,                   | -   |
| 3              | or Att  | Certification: | 4 Homicide   | mined                         | build                       | ding, etc          | c. (Specify,        | )                   |   |                   |                         |              | City o                      | r Tòwn,                     | State)              |                                  |                                    |     |
|                | To the Hospital or Atter<br>within 24 hours after de<br>To the Funeral Directo<br>completely filled in by th  |                |  |                               |                             |                    |                     |                     |   |                   |                         |              |                             |                             |                     | manner as                        | stated.<br>to the cause(s)         |     |
|                | the H<br>nin 24<br>the F  | ledical        | one)   |                               | and ma                      |                    |                     |                     |   |                   |                         |              |                             |                             |                     |                                  |                                    |     |
|                | <b>5</b> *** <b>6</b> 00  | Σ              | 29b. Signature and title of certif                             |                               |                             |                    |                     |                     | 1 29                                    | _                 | e number                | / . 1        |                             | 29                          | _                   | inea (Month                      | , Day, Year)                       |     |
| )              | - 1   |                | Clan 7   |                               | Ke                          | ga                 | 2011                | 2001/1              | Drine                                   |                   | 22                      |              |                             |                             |                     |                                  | 03                                 |     |
|                | 20  |                | Alan Second  | i who col                     | .D.                         | 501 d              | o F                 | 23a) (Typi          | - (ales                                 | 2 R               | d 5                     | i) ve        | v Sv                        | oi n                        | S. M                | D 20                             | 0910                               |     |
|                | Sta   | te             | 31. Date filed (Month, Day, Yea                                | r)                            | 32.                         | Registra           | ar's Signat         | ure                 | -                                       | -                 |                         |              |                             | ,                           | <i>y</i> , ,        |                                  |                                    |     |
|                | Registr   | ar             | MAY 2  | 8 201                         | 08                          | Lotte              | ar s                | Jr. A               | sall.                                   | /                 |                         |              |                             |                             |                     |                                  |                                    |     |
| _              |   |                |  |                               | 9                           |                    |                     | # 4                 | ,                                       |                   |                         |              |                             |                             |                     |                                  |                                    |     |

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 ear Month May **Physician** 24, 12:00pm<sup>M</sup> James R. Christian /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Woodbine 5934 Woodbine Road #14 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 1 M 2 □ F 51 Yrs 220-48-2762 MD Director 1957 Jan 7. Usual Residence of Decedent d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, has "tedical Examinar traumatic event, has "tedical Examinar traumatic event, has "tedical Examinar traumatics. 10d. Inside City Limits 10h. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Woodbine Director MD Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21797 5934 Woodbine Road #14 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Baker / Cook State of Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James C. Christian Gladys Marie Trent ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trat once. Mr. James Christian (Father) 303 Chelsea Court Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🎇 Burial 2 □ Cremation 3 □ Removal from State McKendree Cemetery 5/28/08 West Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Address of Facility
FUNERAL HOME & CHAPEL, P.A. 22. Name and A HAIGHT Hard MC0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Obstructure yaas **Physician** Monic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) e attending physician and d for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No 3 Probably 4 Unknown Yes s been si Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No s certificate has b irector, page 2 sh autopsy performed? Yes 2 No 1 🗆 Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the t 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital racertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D34849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg MD 10 -iberty S lan 32 Registrar's Signature 31. Date filed (Mog State

Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2 0 8 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 2008 **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) If Under 1 Year 7. Age (In vrs. last birthday 5. Social Security Number Funeral Months Davs 1 ☐ M 2 🖫 F 86 WV 235-20-5681 March 11 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County Marriottsville 1 ☐ Yes 2 👿 No Carroll MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21104 7032 Wellington Drive Funeral 14. Race · American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give A Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 21 No white Completed by 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) domestic Elementary/Secondary (0-12) College (1-4or 5+) homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carmen DeMaria Mark Dingo ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7032 Wellington Dr., Marriottsville, MD 21104 Edith Shigley (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Shinnston Masonic Cem 5-27-08 Shinnston, WV 22. Name and Address of Facilitaight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ (Parak Hariaht Ste P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner A pue be executed burial-trans Due to (or as a consequence of) attending physician for use as the buria The law requires that the death certificate IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 HInknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed 2 □ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director, I. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Unursing Home 5 Residence 6 Other (Specify) Hospital: 3□ DOA 1 Yes 2 No 1 Inpatient 2 ER/Outpatient Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury 28b. Time of 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 1 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

State Registrat

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

Stone 32 Registrar's Signature

MA

MAY 28 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

#### State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** J. Connor 0.5 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 4800 Yellowwood Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 0 9 2 5 4 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 □ M 2 T□ F Director 214-40-7702 Yrs. 64 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location item 27 is marked other than "naturel", or items 23a or 28e-f show other traumatic event, the Medical Examinar must be motified at **Funeral Director** Baltimore MD NA 10f. Zip Code 10e. Street and Number 21209 4800 Yellowwood Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 [X]No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Clerk na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mentai em 27 is marked o McQueen Connor Lessie Hanton ൧ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Connor-Nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit, Pages 1 Department of H Important: If Ite eny injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/28/08 21. Signature of Foneral Service Li 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner •pital or Attending Physician: The law requires that the death certificate be executed usus after death. Fig. 1 Pirector: After this certificate has been signed by the attending physician and filled in by the turnest director, page 2 should be detached for use as the burital-transit Athers clerk Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) <u>М</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ Completed 25. Was case referred to medical examiner? Be 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Tes 2 🗆 No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one)

and manner stated.

(e)=

distrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3209 Greenmeade Road, Baltimore, Md 21209 20c. Location - City or Town, State Woodlawn, 21215 Baltimore, Approximate Interval Between Onset and Death 23d. Date of delivery Month Yea 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 🗆 🗅 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Day, Year) 29c. License number

23

43

2008

4c. County of Death

10g. Citizen of What Country? U.S.A.

16b. Kind of Business/Industry

14. Race - American Indian.

Black

Social Security Adm.

Black, White, etc.

2:27p.M

9. Birthplace (State or Foreign Country)
SC

10d, Inside City Limits

1 X Yes 2 ☐ No

State Registrar 29b. Signature

31. Date filed (Month, Day,

title of certifier

Year)

2 8 2008

tomes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician EVELYN** CLAYTON 2008 MAY 23 5:10 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FOREST HILL HEALTH & REHABILITATION FOREST HILL HARFORD If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 🗓 F **Director** 214-01-5606 92 02/03/1916 Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√2 No Director MD Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral 21047 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.

Int: If item 27 is marked other than "natural", or items 23 any or other traumatic event, the Medical Examiner must 1806 Harford Road U.S.A.

14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ [X]No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Bruce M. Smith Senu M. Clayton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health Important: If item 27 any Injury or other tr once. Janet L. Sites (daughter) 2328 Gibson Road - Forest Hill, Maryland 21050 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Fork U.M. Church Cem: 05/27/2008 | Fork, Maryland 21. Signature of Funeral Service Lic, n ee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 assa 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Uneaco or rijery that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examine burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician the as attending properties for use as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 □ No 2 No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ို 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation Injury Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physiclan: The law requires that the death certificate be executed s after dec. ral Director. After filled in by

within 24 hours a

State Registrar

Medical

(Check only

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. DAVID DUNN - 615 W. MACPHAIL ROAD - BEL AIR, MD 21014 31. Date filed (Month, Day, Year) MAY 2 8

32 Registrar's Signature 2008

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

P32295

29d. Date signed (Month. Dav. Year)

200

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** PRAW/ TORY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner** 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min MARY AND 1 □ M 2 🗗 JUNE Yrs. Director sidence of Decedent 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, it a Medical Expositational by notified at 1 ☐Yes 2 ☐ No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No BLACK Maryland 21215-0036 à 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT usp retired) Elementary/Secondary (0-12) College, (1-4or 5+) NA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) -515TER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 23a. Part F. by the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock o neart failure. List only one cause on each line. Immediate ause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I detached contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. 2 1 Tes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 100 1 □Yes 2 □ No 1 ☐ Yes Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 Yes 2 No 6 Cother (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this ō 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident iours after death. neral Director: / / filled in by the f 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) To the I within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** A M 20 2008 Iris Kernodle Del Vecchio Cotter May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rockville Montgomery Shady Grove Adventist Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Social Security Number **Funeral** Year. Days Hours 1 □ M 2 🖾 F December 8, 1923 Washington, D.C84 Director 577-42-1608 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Damascus Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with United States 20872 10900 Longmeadow Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2₹ No Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: White þ 3 ☐ Widowed 4 ₺ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Nursery Schools Art Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental H Be and 2 should be Iris Katherine Kernodle Samuel Del Vecchio 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 2 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 1 and 2 an 1608 Arbor View Road, Silver Spring, MD 20902 Patrick Cotter / Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State May 27, 2008 Olney, Maryland Norbeck Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Lic M01473 Bethesda, Maryland 20814-3501 7557 Wisconsin Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cecal Volvulus Days Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transi Exami Due to (or as a consequence of): Box 68760, certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2X No Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached o 9 Unknown 9 Unknown σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No 1⊠Yes 2□No After this certific 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 20, 2008 MD63623 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Medical Center Drive, #233, Rockville, MD 20850 Jason A. Brodsky, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) MAY 28 2008 Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 1700PM May 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NION Memoria 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 <del>□</del> M 2 □ F 215-32-01S6 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland nd Mental Hygiene.
marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County must be notified at Saltimore 1 <del>□ Yes</del> 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Eve Armed Forces? 1 Yes 2 Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) - American Indian 11. Marital Status Black, White, etc. Examiner 1 ☐ Never Married 2 ☐ Married Specify: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) river 18. Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 Is marked o injury or other traumatic ၉ 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number of Orothi KB/200 Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition 20c. Location - City or Town, State 1☐Burial 2☐Cremation 3☐Removal from State Baltimore, M 4 ☐ Donation 5 ☐ Other (Specify) C. Oreene Funeral Services 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4905 York 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 240 **Physician** ww /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit this certificate has been signed by the attending physician and al director, page 2 should be detached for use as the burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 ☑ nknown 2 □ No 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1□ Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1. Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manuer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident filled in by the 6 ☐ Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) word Hospital trible mon

Registrar

State

31. Date filed (Month, Day, Year)
MAY 2 8 2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03896 State of Maryland / Department of Health and Mental Hygiene 2008 Carolyn Dunyoh Certificate of Death 1- For State Registrar 2. Date of Death Physician/ 1750 hrs May 21, 2008 Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institutio Baltimore 4900 Goodnow Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State of If Under 1 Year If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Foreign **Funeral** Days Hours Months Country) Director M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 1 Yes 2 No 28a-f show death with the Maryland 10g. Citizen of What Country? Funeral Director 10e. Street and Number 11206 14. Race - American Indian, Black, Was Decedent of Hispanic Ongin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status White, etc. Armed Forces? 1 Never Married Yes Specify Yes 2 No specify: Imore, MD 21215-0036
Pages 1 and 2 should be filed within 72 hours after c nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Yes, Give Yea 3 4 Divorced 16b. Kind of Business/Industr 16a. Decedent's Usual Occupation (Give kind of work done 3 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) ho event, the Medical <u>Dresentative</u> 17. Father's Name (First, Middle, Last) Be wn, State, Zip Code) (Street and Number or Rural Route Number, City or To 19b. Mailing Address 19a. Informant's Name/Relationship (Type, Print) more 501 rabia 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition crematory or other place) timore, Removal from State 2 Cremation 3 or other permit. Pages Department or Important: Greene Funeral Services 4 Donation 5 Other Specify 21. Signature of Funer | Service Ligense Baltimore, MD York And Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Retween Onset and Physician failure. List only one cause on each line Death /Medical Complications of autoimmune disease Immediate Cause (Final disease 'xaminer Due to (or as a consequence of): or condition resulting in death) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and led for use as the burial - transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED 27, XX UNPENDED G881 7/10/08 TT perME 23d Date of delivery Box 68760 23c. If yes, outcome of pregnancy Year Day Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? ficate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. Yes 2 No 3 Probably 4 ✔ Unknown څ 24b. Were autopsy findings available Completed 24a. Was an prior to completion of cause of After this certificate has been funeral director, page 2 should autopsy death? performed? 1 🗸 Yes ✓ Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Nursing Home 5 Residence 6 Other: Scene Division of Vital Be Other-Hospital: 1 examiner? DOA 2 ER/Outpatient Inpatient 1 🗸 Yes ۵ 28d. Describe how injury occurred 28c. Injury at Work? 28h Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: Yes 2 No 1 X Natural Pending Fo the Funeral Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City Investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Si natui May 22, 2008 O.C.M.E.

State

**OCME 2006** 

31. Date filed (Month, Pa Registra OCME DHMH 17 Rev 1/2001

Laron Locke MD.

ne and address of person who completed cause of death (Item 23a)

2008 8

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 17160

| 11501 Progress Lane Princess Anne Some  Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/Y  |  |
|--|--|
| 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 11501 Progress Lane Princess Anne  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/Y   | 3. Time of Death<br>1218 hrs   |
|  | unty of Death<br>Ierset  |
| Director 363-84-0791 1X M 2 F 46 Yrs. Months Days Hours Min. 03/17/1962  | 9. Birthplace (State or Foreign Country)   |
| Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MI Alpena Wilson Township  10b. Street and Number 10g. Citizen of Decedent  10c. City, Town or Location  Wilson Township  | 10d. Inside City Limits 1 Yes 2 X No   |
| The Report of the Wilson Township  10e. Street and Number  3486 Donnan Road  49744  Unite  | of What Country?<br>ed States  |
| 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. F  15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   | Race - American Indian, Black,<br>White, etc.<br>ecify: White  |
| The state of the s | of Business/Industry   |
| Welder Comm  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sum  18. Mother's Name (First, Middle, Maiden Sum  18. Mother's Name (First, Middle, Maiden Sum  18. Mother's Name (First, Middle, Maiden Sum  18. Mother's Name (First, Middle, Maiden Sum  18. Mother's Name (First, Middle, Maiden Sum  19. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or  | name)  |
| Description of the first state of Disposition   19b. Mailing Address   Street and Number or Rural Route Number, City or 2   19a. Informant's Name/Relationship (Type, Print )   19b. Mailing Address   (Street and Number or Rural Route Number, City or 2   2   2   2   2   2   2   2   2   2   | 49707  |
| The state of the s |  |
| 21. Signature of Funeral Service Licensee M01113  22. Name and Address of Facility Bannan Funeral 222 S. Second Avenue, Alpena, M  | Home<br>MI 49707   |
| Physician  /Medical  Sxaminer  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.  Immediate Cause (Final disease a. Multiple Injuries  | or heart Approximate Interval<br>Between Onset and<br>Death  |
| or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.  |  |
| if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):   |  |
|  |  |
| 9 by 15 to 19 W IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Da   | ate of delivery<br>nth Day Year  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use of the part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  1 Yes 2 No   | contribute to the cause of death?  D 3 Probably 4 Unknown  |
| 24a. Was an autopsy performed? 1   | 24b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No                                  |
|  | 6 ✔ Other: Scene   |
| 25. Was case referred to medical 26. Place of Death (Check only one)  Hospital: Inpatient 2 ER/Outpatient 3 DOA Other, Nursing Home 5 Residence  | occurred   |
| Definition of Death (Check only one)  25. Was case referred to medical examiner?  1  | arik explosion   |
| 25. Was case referred to medical examiner?  1  | Number or Rural Route Number, City   |
| 25. Was case referred to medical examiner?  1  | Number or Rural Route Number, City Princess Anne, MD anner as stated.  |
| So was case referred to medical examiner?  1   | Number or Rural Route Number, City Princess Anne, MD  anner as stated. and due to the cause(s) e signed (Month, Day, Year) |
| 29d. Date  | Number or Rural Route Number, City Princess Anne, MD  anner as stated. and due to the cause(s) e signed (Month, Day, Year) |

OCME

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2008 11:25A Roque Felix Dias Mav /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6004 Avon Drive Bethesda Montgomery Birthplace (State or Foreign Country) Under 1 Year | If Under 24 Hrs. onths Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 ☐ F Oct. 8, 1919 India Director 088-70-2338 88 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 XNo Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6004 Avon Drive 20814 Portugal Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Mamed 1 ☐ Yes 2 💢 No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Government of Portugal 5+ Diplomat 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julieta Saldanha ပ <u>Reginaldo Dias</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5917 Rudyard Drive, Bethesda, Maryland 20814
of Disposition (Name of Date 20c. Location - City or Town, State Joseph R. Dias/Son 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Montgomery Prium, Inc. May 29, 2008 | Bethesda, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 ☐ Donation 5 ☐ Other (Specify) Crematorium. 21. Signatu and Fund ral Service Licen .M00803 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC UBSTRUCTIVE LUNG DISEASH 2011 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical the as use 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No the detached 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 XVo 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe certificate 2 X No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2500 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Hospital or Attending 1 ANatural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier D40216 May 27, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis A. Cullen, M.D. 7625 Wisconsin Avenue, #101, Bethesda, Maryland 20814 32 Tegistrar's Signature 31. Date filed (Month, Day, Year) State MAY 28 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** BERNARD BINTZER 65 25 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A LEVINDALE HEBREW HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Months Hours 09/10/1915 RUSSIA 92 112-03-7089 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State sa or 28a-f show t be notified at 1 ☐ Yes 2 No Director BALTIMORE RANDALLSTOWN MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21133 USA 4247 MARY RIDGE DRIVE 7 is marked other than "natural", or Items 23a traumatic event, the Medical Examiner must be 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify. Specify. ρ WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene. 7 is marked other than " College (1-4or 5+) Elementary/Secondary (0-12) PROPRIETOR DRY CLEANERS 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be DINTZER JENNIE PRINZ **JOSEPH** ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n any Injury or other traun 4247 MARY RIDGE DRIVE, RANDALLSTOWN, MD 21133 NADINE DINTZER / DAUGHTER 20a. Method of Disposition 1 Description 2 Cremation Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of 3 ☐Removal from State BETH EL MEMÓRIAL PARK 05/27/2008 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) of Funeral Servi 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 nplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, your cause on each line. Approximate Interval Between Onset and Death Part . Enter the disease, of cent shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) CONGESTIVE Physician H GART FAILURE /Medical Due to (or as a consequence of): **Examiner** CORON ARY ANTER D15645E Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) After this certificate has been signed by the functional director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by FAILURE RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 1 Yes 2 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1-Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide

or Attending Physician:

24 hours after death e Funeral Director: within 24 hor To the Fune completely f

10

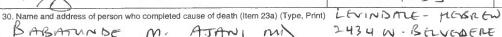
BABATUNDE 31. Date filed (Month, Day, Year) State MAY 2 8 2008 Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

Medical



PHYSICIAN

and manner stated.

32 Registrar's Signature

2434 W. BELVEDENE AVE-

1/Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0064533

29d. Date signed (Month, Day, Year)

05 - 26 - 2008 CIEVUATRIC CITE

BATTMORE, MI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Yea Month **Physician** 23 Ebror May 1:30AM OPhelia 2008 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Stella Maris Hospice Imonium Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) 6. Sex **Funeral** Hours Months 1 □ M 2 XF Days 214.22.048 81 Director Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b County 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Profice Examiner must be redfilled at once. Baltimore MD atonsville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Black <u>م</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Distribution Company Elementary/Secondary (0-12) College (1-4or 5+) Mail Handler unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JONES Mar ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 19a. Informant's Name/Relations Vargis Circle Apt. 3A Windsor Mill MD Son James llor 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐ Removal from State 05 National vland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaughn C 21. Signature of Funeral Service Licent . Greene Funeral Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, each as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician **PNEUMONIA** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 **X** No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 □Yes 2 K No 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1∐Yes 2 No HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

11:30 а.ш.

OPHELIA EBRON

2300 DULANEY VALLEY RD.
32 Registrar's Signature ERNESTINE WRIGHT

30. Name and a dress of person who completed cause of death (Item 3a) (Type, Print)

TIMONIUM, MD 21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day ERHARI 08 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel 728 214th Street Pasadena If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) April 4,1922 6. Sex Months Days Hours Min. 1 □ M 2 🕱 F 86 214-18-3419 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2X No Pasadena Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21122 U.S.A. 728 214th Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc 1 Never Married 2 Married ☐Yes 2 Yes, Give 1 ☐ Yes 2 X No Specify White Specify. 3 X Widowed 4 ☐ Divorced Ye ar or Dates: Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Blanche (unknown) Roger Drury 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 728 214th Street Pasadena Maryland 21122 Ms. Loretta J. Everhart/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Mem. Park Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation of Funeral Service Licenses Services 1 2nd Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):

Physician /Medical Examiner

**Physician** 

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

þ

Completed

Be

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Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate has been signed by the irector, page 2 should be detached ģ Be Completed Certification: To

Division of Vital Records, P.O. Box 68760,

| that initiated events   | C   |  |
|---|---|--|
| resulting in death) Last  | Due to (or as a consequence of):  |  |
|   | . d   |  |
|   |   |  |
| IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 No<br>9 □ Unknown | 23c. If yes, outcome of pregnancy  1  | 23d. Date of delivery<br>Month Day Year  |
| Part II. Other significant conditions of  | contributing to death but not resulting in the underlying cause given in Part I. 23e. Did   | tobacco use contribute to the cause of death?  |
|   | 10  | Yes 210 No 3 Probably 4 Unknown  |
|   | pe  | as an lopsy as an lopsy findings available prior to completion of cause of death   2 No   1   Yes 2   No |
| 25. Was case referred to medical examiner?  | 26. Place of Death (Check only  | y one)   |
| 1 Yes 2 No  | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   | esidence 6 Other (Specify)   |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation                              | (Month, Day, Year) Injury Work?   | e how injury occurred  |
| 3 Suicide 6 Could not be 4 Homicide determined  | 286. Place of injury - At nome, farm, street, factory, office 28f. Location   | (Street and Number or Rural Route Number,<br>own, State)   |
| 29a. Certifier (Check only one)   | nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time and manner stated. | ne cause(s) and manner as stated.<br>e, date and place, and due to the cause(s)                          |

29d. Date signed (Month, Day, Year)

ENSE HIGHWAY A NNAPULIS MD 21401

State Registrar

Medical

29b. Signature and title of pertific

Name and address of person who

32 Registrar's Signature

completed cause of death (Item 23a) (Type, Print

17165

|                                |   |                     | For State Registrar   | - State of 4018                                      | -                                  | artment of He<br>rtificate of D                                     |   | -   | en <b>∉_UUO</b><br>g. No.                   | 1/103                                 |
|--------------------------------|---|---------------------|---|--|------------------------------------|---|---|---|---|---------------------------------------|
|                                | Div. et et  |                     | 1. Decedent's Name (First, Middle, L  | ast)   |                                    |   |   | 2. Date of Death<br>Month                     | Day Year                                    | 3. Time of Death                      |
|                                | Physici<br>/Medic   |                     | Carole Laverr   | ne Eason   |                                    |   |   | May   | 23 200                                      | 8 11:14A                              |
| E.                             | Examin  |                     | 4a. Fecility Name (If not institution, g  | ive street and number)                               |                                    | 4b. City, Town, or I  |   |   | 4c. County of Dea                           |                                       |
|                                |   |                     | 9346 Reader Lane  |  |                                    | Columbi   |   |   | Howa  |                                       |
|                                | Funeral   |                     |   | Sex 7. Age<br>1  M 2                                 | e (In yrs. last birthday)          | If Under 1 Year<br>Months Days                                      | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birth<br>(Month, Day, )<br>July 15 | Year) 9. Bi                                 | rthplace (State or Foreign<br>ountry) |
|                                | Director  |                     | 254-45-2152 Usual Residence of Decedent   |  | 41 Yrs.                            |   |   | July 15                                       | ,1966 Ge                                    | orgia                                 |
|                                | land<br>ow  |                     | 10a. State 10b. County  |  | 10c. City, Town or Lo              | ocation   |   |   |   | 10d. Inside City Limits               |
|                                | Many<br>feb   | ō                   | Maryland Howa   | ard  | Columb:                            | ia  |   |   |   | 1 ☐ Yes 2 🔼 No                        |
|                                | the   | rec                 | 10e. Street and Number  |  |                                    | 10f. Zip Code   |   | 100   | g. Citizen of What C                        | country?                              |
|                                | 72 hours after deeth with the Maryland<br>'naturel', or Items 23a or 28s-f ehow<br>dical Examinar must be notified at   | by Funeral Director | 9346 Reader Lane  | <u> </u>   |                                    | 21045   |   |   | U.S.A.                                      |                                       |
|                                | deeti   | ner                 | 11. Marital Status  | 12. Was Decedent I                                   | Ever in U.S. 13.                   | Was Decedent of His<br>If Yes, specify Cuban                        | spanic Origin? (Spe                       | cify Yes or No-                               | 14. Race - Am<br>Black, Wh                  | erican Indian,                        |
| 9                              | or Ite  | F                   | 1 Never Married 2 Married   | Armed Forces? 1 ☐ Yes 2 244 If Yes, Give             | No.                                | 1 ☐ Yes 2 X No  | Specify:                                  | Tiball, Glo.)                                 | Consider                                    |                                       |
| 8                              | urel'.  | d b                 | 3 ☐ Widowed 4 ☑ Divorced  | Year or Dates:                                       |                                    |   |   |   |   | lack                                  |
| 5                              | 72 h<br>natu  | Completed           | 15. Decedent's<br>(Specify only highest g   | Education<br>rade completed)                         | 16a. Dece<br>(Give                 | dent's Usual Occupat<br>kind of work done du<br>DO NOT use retired) | tion<br>uring most of workir              | ng 16   | 6b. Kind of Busines:<br>US Bureau           |                                       |
| 12                             | within ne.  | m<br>du             | Elementary/Secondary (0-12)   | College (1-4or 5                                     | i+) )                              | pecialist   |   |   | Statistic                                   |                                       |
| 2                              | Hygie<br>Hygie<br>ther i  |                     | 17. Father's Name (First, Middle, Las   | <b>-</b>   | 11 2                               | <u> </u>  | 18. Mother's Name                         |   |   |                                       |
| ano                            | d be  | Be c                | Emanuel Larkin,   |  |                                    |   | Rosalee                                   |   |   |                                       |
| 2                              | should<br>nd Me<br>mark<br>mati   | 은                   | 19a. Informant's Name/Relationship  |  | 19b. Maili                         | ng Address (Street ar   |   |   | City or Town. State.                        | Zip Code)                             |
| Ma                             | nd 2 s<br>Ith ar<br>27 ts<br>1 treu   |                     | Mario Eason (So   |  |                                    | Reader La   |   | mbia, MD                                      |   | _,p                                   |
| ē,                             | Hea<br>Hea<br>tem   |                     | 20a. Method of Disposition  |  | 20b. Place of Dispo                | sition (Name of   | ! D                                       |   | Oc. Location - City o                       | r Town, State                         |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28a-f ehow any injury or other treumatic event, tre Medical Exactinar must be notified at once. |                     | 1 ☑ Burial 2 ☐ Cremation 3<br>4 ☐ Donation 5 ☐ Other (Spec                        |  |                                    | matory or other place<br>ip Cemeter                                 | 1   | -2008 M                                       | illedgevi                                   | lle. GA                               |
| <b>=</b>                       | orter   |                     | 21. Signature of Funeral Service Lic  |  |                                    | -1  | -   |   | 1110age v 1                                 | 110, 01                               |
| ä                              | Depa<br>Impo<br>eny in  |                     | > 4mgx . Had  | manmo  | 1050 W                             | Name and Address<br>itzke Fune<br>555 Twin K                        | eral Homes<br>Knolls Roa                  | ad Colu                                       | mbia, MD                                    | 21045                                 |
|                                |   |                     | 23a. Part1. Enter the disease, or co<br>shock, or heert failure. List on          | mplications that caused                              | the death. Do not en               | ter the mode of dying   | , such as cardiac of                      | r respiratory arres                           | st,   | Approximate<br>Interval Between       |
|                                | Physician   |                     | Immediate Cause (Final disease or condition                                       | Brias  |                                    | mitast  | L sika                                    | luxe  | 18086                                       | Onset and Death                       |
| P.                             | /Medical  |                     | resulting in death)   | a  | a consequence of):                 | 77(703  | 10  | 31  |   | 12 House                              |
|                                | Examiner  |                     | Conventinity flat equalities  | 600  | . 9 -                              |   |   |   |   |                                       |
|                                | שוו ב   | Examiner            | Sequentially list nonditions if any, leading to immediate cause. Enter Underlying | Due to (or as  | a consequence of):                 |   |   |   |   |                                       |
|                                | acute<br>and<br>trans   | am                  | Cause (Disease or injury that initiated events resulting in death) Last           | c  |                                    |   |   |   |   |                                       |
| 30,                            | oe ex   |                     | resulting in deathly Last   | Due to (or as  | a consequence of):                 |   |   |   |   |                                       |
| 68760,                         | ificate be executed<br>physicien and<br>as the burial-transit   | edicai              | •   | d  |                                    |   |   |   |   | 1                                     |
|                                |   | /Me                 | IF FEMALE:  | 23c. If yes, outcome                                 | of pregnancy                       |   |   |   | 1   | 100-100-1                             |
| Вох                            | etten<br>for us   | ian                 | 23b. Was decedent pregnant in the past 12 months?                                 |  | 2 Fetal death 3                    | Ectopic pregnancy Other (specify)                                   |   |   | 23d. Date of de<br>Month                    | Day Year                              |
| P.0.                           | The law requires that the death certifeles been signed by the ettending page 2 should be detached for use a   | Physician/M         | 1 ☐ Yes 2 No<br>9 ☐ Unknown   | 9 Unknown  | tano di doatii 30                  |   |   |   |   |                                       |
| ۵.                             | that<br>ed by<br>deta   | P                   | Part II. Other significant conditions   | contributing to death be                             | ut not resulting in the u          | nderlying cause givei   | n in Part I.                              | 23e. Did toba                                 | acco use contribute                         | to the cause of death?                |
| ds                             | uires<br>n sign   | d by                | Animia  | Jaundice   | hior                               | r 5016.   | C1  | 1 🗆 Yes                                       | 2 00 No 3 □ F                               | Probably 4 Unknown                    |
| Ö                              | w rec   | Completed           | •   |  |                                    |   |   | 24a. Was an                                   | 24b. Were a                                 | utopsy findings available             |
| Be                             | he tay<br>e hes<br>age 2  | mo                  |   |  |                                    |   |   | autopsy<br>performe                           | prior to<br>death?                          | completion of cause of                |
| tal                            | an: T   | 0                   | 25. Was case referred to medical  |  |                                    |   | 26. Place of Death                        |   | XNo 1□Ye                                    | s 242                                 |
| <u> </u>                       | ysici<br>is cer<br>direci   | To B                | examiner? 1 Tes 2 No  | Hospital:  | nt 2 ☐ ER/Outpatier                | Oth   |   |   | ice 6 Other (Sp                             | ecify)                                |
| ō                              | g Ph  |                     | 27. Manner of Death   | 28a. Date of Injur                                   | ry 28b. Time o                     |   |   | 8d. Describe how                              |   |                                       |
| ō                              | ath.<br>pr: Aff   | atio                | 1 Natural 5 Pending 2 Accident investigati  |  | , rour, injury                     |   | es 2 □No                                  |   |   |                                       |
| Division of Vital Records,     | l or Atte<br>efter de<br>Directo<br>I in by th  | Certification:      | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine                               |  | ury - At home, farm, str           | reet, factory, office   | 2   | 8f. Location (Stre                            |   | Rural Route Number,                   |
| Ω                              | Itel o<br>urs eff<br>rel Di   |                     |   |  |                                    |   |   |   |   |                                       |
|                                | To the Hospitel or Attending Physician: The I within 24 hours efter death.  To the Funerel Director: After this certificete he completely filled in by the funeral director, page   | Medicai             | (Check only 2 Medical Ex  | Physicien: To the best of<br>aminer: On the basis of | examination and/or in              | h occurred at the time<br>vestigation, in my opi                    | e, date and place, a inion, death occurre | nd due to the cau                             | use(s) and manner a<br>te and place, and du | as stated.<br>ue to the cause(s)      |
|                                | To the hwithin 24<br>To the Complete  | Med                 | one) 29b. Signature and title of certifier  | and manner eta                                       | ited.                              | 29c. License  |   |   | d. Date signed (Mor                         |                                       |
| \ \                            | or To   | -                   | 1) M  | 2000   | N)O                                |   | 0573                                      | 1   | 5-23-08                                     |                                       |
| ,                              |   |                     | 20 Name of the 17   | a completed  |                                    |   | )   |   | - 0.5                                       |                                       |
|                                | 10  |                     | Jon Kent Minford  |  | eath (Item 23a) (Type.  ttle Patux |   | Columbia                                  | MA 210  | V./.  |                                       |
|                                | Sta   | te                  | 31. Date filed (Month, Day, Year)   | 32. <b>13</b>  | ar's Signature                     | CIIL FRWY.  | COTOMINTS!                                | ru. ZIU                                       | <del>/   '  </del>                          |                                       |
|                                | Registr   |                     | MAY 2 8   | 2008   | ar's Signature                     | sere!   |   |   |   |                                       |

State of Maryland / Department of Health and Mental Hygien 2008

|                     |  |                               | For<br>State<br>Registrar  | State of Ma   | aryland / Depa<br><i>Cei</i>                    | artment of H<br><i>rtificate of L</i>                             |   |  | ien <b>2</b>                                  | 17166  |  |  |  |  |  |
|---------------------|--|-------------------------------|--|---|---|---|---|--|---|--|--|--|--|--|--|
|                     | Physici  | an                            | 1. Decedent's Name (First, Middle<br>Anne Fleischma  | 7.1   |   |   |   | 2. Date of Death<br>Month<br>05-22-          | Day Year                                      | 3. Time of Death 420 P M                         |  |  |  |  |  |
|                     | /Medio   |                               | 4a. Facility Name (If not institution,   |   |   | 4b. City, Town, or  | Location of Death                         | 03-22-                                       | 4c. County of Dea                             |  |  |  |  |  |  |
|                     | Lxaiiii  | CI                            | 457 Crisfield  | Drive   |   | Abingdo   | n   |  | Harford                                       |  |  |  |  |  |  |
|                     | Funeral<br>Director  |                               | 219-26-7328  | 6. Sex 7. Ag<br>1 ☐ M 2 <b>X</b> F                                  | e (In yrs. last birthday)<br>70 Yrs.            | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birth<br>(Month, Day,<br>03-21-19 | 9. Bir<br>938 Ma                              | thplace (State or Foreign<br>ountry)<br>ryland   |  |  |  |  |  |
|                     | and  |                               | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town or Lo                           | ocation   |   |  |   | 10d. Inside City Limits                          |  |  |  |  |  |
|                     | Maryl<br>-f ehc  | tor                           | Maryland Harf  | ord   | Abingd  | on  |   |  |   | 1 ☐ Yes 2 No                                     |  |  |  |  |  |
|                     | r 28a  | rec                           | 10e. Street and Number   |   | I   | 10f. Zip Code   |   | 10   | 0g. Citizen of What C                         | ountry?  |  |  |  |  |  |
|                     | 23a c  | a D                           | 457 Crisfield  | Drive   |   | 21009   |   |  | USA   |  |  |  |  |  |  |
| 980                 | permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other treumatic avent, The Medical Examinal must be notified at ADES. | Completed by Funeral Director | 11. Marital Status  1 Never Married 2 X Marrie 3 Widowed 4 Divorced  | 12. Was Decedent Armed Forces? 1  Yes 2 1 Yes, Give Year or Dates:  | No  | Was Decedent of Hi<br>If Yes, specify Cubar<br>1 ☐ Yes 2X No      |   | ecify Yes or No-<br>Rican, etc.)             | 14. Race - Am<br>Black, Whi                   |  |  |  |  |  |  |
| 5-0                 | 72 ho  | eted                          | 15. Decedent'<br>(Specify only highes  | s Education<br>t grade completed)                                   | 16a. Dece                                       | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired | ation<br>during most of work              | king   | 16b. Kind of Business                         | /Industry  |  |  |  |  |  |
| 2121                | d within<br>giene.<br>or then  | ompl                          | Elementary/Secondary (0-12)  | College (1-4or  |   | on NOT use retired, ing Compa                                     |   |  | Health  | Care   |  |  |  |  |  |
| Maryland 21215-0036 | uld be file<br>fental Hyg<br>rkad othe   | To Be C                       | 17. Father's Name (First, Middle, L<br>Joseph Adelsbe  |   |   |   | 18. Mother's Nam<br>Adele                 | e (First, Middle, M<br>Wood                  | Maiden Sumame)                                |  |  |  |  |  |  |
| lary                | and N<br>is ma   |                               | 19a. Informant's Name/Relationsh   |   |   |   |   |  | City or Town, State,                          | Zip Code)  |  |  |  |  |  |
|                     | l and<br>lealth<br>im 27<br>her tr   |                               | Carl Fleischman  | n (Husband)   |   | Crisfield   |   |  |   | Town State                                       |  |  |  |  |  |
| mor                 | Pages I<br>ent of H<br>nt: if ite<br>ry or ot  |                               | 20a. Method of Disposition  1 → Burial 2 → Cremation  4 → Donation 5 → Other (Sp.  |   |   | osition (Name of<br>matory or other place<br>of Faith             | 1   |  | 20c.Location - City or<br>Baltimore,          |  |  |  |  |  |  |
| Baltimore,          | permit. I<br>Departm<br>Importar<br>any inju   |                               | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc. 610 W. MacPhail Rd Bel Air, MD 21014  |   |   |   |   |  |   |  |  |  |  |  |  |
|                     |  |                               | 23a. Pact. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, affock, or heart failure. List only one cause on each line.  Approximate Interval Between |   |   |   |   |  |   |  |  |  |  |  |  |
|                     | Physician  |                               | Immediate Cause (Final disease or condition  |   | SCIERDIL  | C CARDI   | DVASCL                                    | ILHR I                                       | SEASE   | Onset and Death                                  |  |  |  |  |  |
|                     | /Medical<br>Examiner   |                               | resulting in death)  |   | a consequence of):                              |   |   |  |   |  |  |  |  |  |  |
|                     | p ii   | iner                          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | b. Due to (or as  | a consequence of):                              |   |   |  |   |  |  |  |  |  |  |
| ,                   | ficete be executed<br>physicien and<br>is the burial-transit   | Examiner                      | that initiated events<br>resulting in death) Last  | c<br>Due to (or as  | a consequence of):                              |   |   |  |   |  |  |  |  |  |  |
| 68760,              | ysicie   | edical                        | N.   | d   |   |   |   |  |   |  |  |  |  |  |  |
|                     |  |                               | IF FEMALE:   |   |   | -   |   |  |   |  |  |  |  |  |  |
| P.O. Box            | The law requires that the death certif<br>sie has been signed by the attending<br>page 2 should be detached for use an   | Physician/M                   | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown   | 23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown           | 2 Fetal death 3                                 | Ectopic pregnancy Other (specify)                                 |   |  | 23d. Date of de<br>Month                      | livery<br>Day Year                               |  |  |  |  |  |
|                     | signed to det  | þ                             | Part II. Other significant condition PARKINSON   |   |   | nderlying cause give  | en in Part I.                             |  | pacco use contribute t                        | o the cause of death?                            |  |  |  |  |  |
| CO                  | w requir<br>been si<br>should  | lete                          | DEMENTIA   |   |   |   |   | 24a. Was a                                   | n 24b. Were a                                 | utonsy findings available                        |  |  |  |  |  |
| of Vital Records,   | : The lay<br>cete has  | Completed                     | 20.00.77.1   |   |   |   |   | autops<br>perform<br>1 Yes 2                 | ned? death?                                   | utopsy findings available completion of cause of |  |  |  |  |  |
| VIE                 | Attending Physician: or death. ector: After this certifically the funeral director, I  | o Be                          | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No   | Hospital: 1 ☐ Inpatie   | int 2 ☐ ER/Outpatier                            | Othe  |   | th (Check only on                            | e)<br>ince 6 □Other (Spe                      |  |  |  |  |  |  |
| ō                   | g Phy<br>er this<br>eral d   | n: To                         | 27. Manner of Death  | 28a. Date of Inju   | ry 28b. Time o                                  | II 3LI DUA  | at Nursing H                              |  | ow injury occurred                            | эспу)  |  |  |  |  |  |
| jo                  | endin<br>salh.<br>or: Aft<br>he fur  | atlo                          | 1 ☑Natural 5 ☐ Pending investig  | ation   | y Year) Injury                                  |   | Yes 2 □No                                 |  |   |  |  |  |  |  |  |
| Division            | ial or Attendi<br>s after death.<br>al Director: A<br>ad in by the fu  | Certification:                | 3 ☐ Suicide 6 ☐ Could n<br>4 ☐ Homicide determi  | ot be<br>ned 28e. Place of Inj<br>building, et                      | ury - At home, farm, sti<br>c. <i>(Specify)</i> | reet, factory, office   |   | 28f. Location (St.<br>City or Town           | reet and Number or R<br>n, State)             | lural Route Number,                              |  |  |  |  |  |
|                     | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificete his completely filled in by the funeral director, page   | ledical (                     | 29a. Certifier 1 Certifying (Check only one)   | Physician: To the best<br>examiner: On the basis o<br>and manner st | examination and/or in                           | h occurred at the tim<br>vestigation, in my op                    | e, date and place,<br>pinion, death occur | and due to the carred at the time, da        | ause(s) and manner a<br>ate and place, and du | s stated.<br>e to the cause(s)                   |  |  |  |  |  |
|                     | To the To the Comp   | Me                            | 29b. Signature and title of certifier  | NA 2 0  | 1.  | 29c. License  | number                                    | 25   | 9d. Date signed (Mon                          | th, Day, Year)                                   |  |  |  |  |  |
|                     | <b>1</b>   |                               | V  | Mollya  | nkar ing  | 00  | 15027                                     | N  | 1AY 23  | 2008   |  |  |  |  |  |
| 6                   | 1  |                               | 30. Name and address of person v   | vho completed cause of c<br>BHYAVVAR                                | eath (Item 23a) (Type,                          | Print)  | VE 9                                      | BEL A  | FIR MD  | 21014  |  |  |  |  |  |
| r                   | Sta  |                               | 31. Date filed (Month, Day, Year)  | 2008 32 Registr   | ar's Signature                                  | and!  |   |  |   |  |  |  |  |  |  |

08-03927 Otto Finnick

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 17167

|   |                       | - For State<br>egistrar   |                                    | C                              | ertificate d              | of D     | eath                                  |                    |            | F                        | Reg. No    | ).                    | 00               | 0 1  | , , ,      |
|---|-----------------------|---|------------------------------------|--------------------------------|---------------------------|----------|---------------------------------------|--------------------|------------|--------------------------|------------|-----------------------|------------------|--|------------|
| Physician   | 1                     | I. Decedent's Name (First, Middle   | e,Last)                            |                                |                           |          |                                       |                    | 2          | . Date of Dea<br>Month   | ath<br>Day | Year                  |                  | 3. Time of Dea                                   |            |
| jedical Examine   | er                    | Otto  |                                    | Α.                             |                           |          | Finn:                                 | ick                |            | May 22, 2                | 2008       |                       |                  | 2015 hrs   |            |
| V   | 4                     | 4a. Facility Name (if not institution<br>Mercy Hospital   | n, give street and n               | umber)                         |                           |          | City, Town, or<br>altimore            | Location o         | f Death-   |                          | 4          | lc. County of         | Death            |  |            |
| Funeral   | ŧ                     | 5. Social Security Number   | 6. Sex                             | 7. Age (In yrs                 | s. last birthday)         | _        | Under 1 Yea                           |                    |            | 8. Date of B             | irth (MN   | N/DD/YYYY)            | 9. Birth<br>Cour | place (State o                                   | r Foreign  |
| Director  | 2                     | 215-28-9867   | 1 X M 2 F                          | 77                             | Y                         | rs.      | Months Day                            | s Hours            | Min.       | 01                       | L 7        | 31                    | 0001             | MD   |            |
|   |                       | Usual Residence of Decedent   |                                    |                                |                           |          |                                       |                    | .1.        |                          |            |                       |                  |  |            |
| v any   | 1                     | 10a. State 10b. County  |                                    | 10c. Ci                        | ity, Town or Loc          |          |                                       |                    |            |                          |            |                       |                  | 10d. Inside Cit                                  | _          |
| Aaryland 28a-f show d at once.  | 5                     | MD  | 1A                                 |                                | Balti                     |          |                                       |                    |            |                          |            |                       |                  | 1 X Yes 2  | No         |
| th the Maryland 23a or 28a-f sho notified at once   | Director              | 10e. Street and Number  |                                    |                                |                           | 10       | f. Zip Code                           |                    |            |                          | 10g. Ci    | itizen of Wha         | at Count         | ry?  |            |
| h the 3a or otifie  |                       | 1811 St. Pau  |                                    |                                |                           |          |                                       | 202                |            |                          |            |                       | . A .            |  |            |
| h with  | ns I                  | 11. Marital Status 1 Never Married 2 Ma   | 12. Was De                         | ecedent Ever in<br>Forces?     |                           |          | ecedent of His<br>specify Cubar       |                    |            |                          | 0-         | 14. Race -<br>White,  |                  | an Indian, Bla                                   | ck,        |
| r death<br>or ite   |                       |   | 1X Yes                             | 2 No                           | ,                         | ٦        | - 01 N                                |                    |            |                          |            | Specify:              | ВІа              | ack  |            |
| s afte  | ⋧┞                    | Widowed 4 Div   | orced If Yes, Give Your Dates:     |                                | 16a Deced                 |          | s 2X No<br>Jsual Occupa               |                    | kind of wo | ork done                 | 16b        | . Kind of Bus         |                  |  |            |
| "natr   | ompieted              | Elementary/Secondary (0-12)   |                                    | (1-4 or 5+)                    |                           |          | of working life                       |                    |            |                          |            | arnes                 |                  | ,  |            |
| 936<br>e.e. than<br>edical  |                       | 8th grade   | na                                 | (                              | Dry                       | Wa.      | ll Fi                                 | nish               | er         |                          | C          | onstr                 | cuct             | ion  |            |
| 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica   | 탉                     | 17. Father's Name (First, Middle,   | Last)                              |                                |                           |          |                                       |                    |            |                          |            | en Surname)           |                  |  |            |
| 215<br>be file<br>ntal H<br>rked<br>ent, t  | ne<br>De              | George Finni  | ick Sr.                            |                                |                           |          |                                       |                    |            | Lowes                    |            |                       |                  |  |            |
| 21215-0036 hould be filed within 7. dould be filed within 7. double Hygiene. is marked other than tite event, the Medica  | - ا≏                  | 19a. Informant's Name/Relations   | hip (Type, Print)                  |                                |                           |          | dress (Stre                           |                    |            |                          |            |                       |                  |  |            |
| nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygene. It: If item 27 is marked other than "natural", or items 23a or 28a-f she other tranmative event, the Medical Examiner must be notified at once TO DO Computed At Engage. | L                     | Brenda Hamli  | in-Stepo                           | daught                         | er 51<br>b. Place of Disp |          |                                       |                    |            | Date                     |            | VIII 6                |                  | 1d 217   | 84         |
| s 1 ar<br>of Heg<br>of Heg  |                       | 20a. Method of Disposition  1 XBurial 2 Cremation   | n 3 Removal                        |                                | crematory or              |          |                                       | metery,            |            | Date                     | 200        | . Localion -          | City Oi          | TOWII, State                                     |            |
| Page<br>Page<br>nent (  |                       | 4 Donation 5 Other Sa   | pecify:                            | , , G                          | arriso                    |          |                                       |                    |            | 28/08                    | 3          | Owing                 | js l             | Mills,   | Md         |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingary or other traumafte event, the Med.   | 1                     | 21. Signature of Funeral Service  | Licensee                           |                                | М                         | ar       | e and Addres<br>ch F/                 | H We               | st         |                          |            |                       |                  |  | _          |
| Add to the second   | 4                     | 23a Part I Enter the disease or   | complications that                 | caused the dea                 | 2 4                       | 30       | O Wab                                 | ash .              | Ave.       | Bal:                     | rrest.s    | hock, or hea          | <u>Md</u>        | 2121<br>Approximate                              |            |
| Physician // // // // // // // // // // // // //  | ľ                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosclerotic Cardiovascular Disease |                                    |                                |                           |          |                                       |                    |            |                          |            |                       |                  | Between O  | nset and   |
| xaminer   |                       | Immediate Cause (Final disease<br>or condition resulting in death)  |                                    | a consequence                  |                           | alov     | ascular Di                            | sease              |            |                          | _          |                       | _                |  |            |
|   | 1                     | Sequentially list conditions,   | b                                  | 1                              | ,-                        |          |                                       |                    |            |                          |            |                       |                  |  |            |
|   | וים                   | if any leading to inmediate cause. Enter Underlying Cause   |                                    | е сольжийся                    | n Ar                      |          |                                       |                    |            |                          |            |                       |                  |  |            |
| W   | ٤١                    | (Disease or injury that initiated events resulting in death) Last   | C                                  | a consequenc                   | e of):                    |          |                                       |                    | _          |                          |            |                       |                  | <del>                                     </del> |            |
| executed an and all - transit   | ֪ׅ֜֝֜֞֜֝֡֡֡֡֝֡֡֡֡֡֡֡֩ |   | d                                  |                                |                           |          |                                       |                    |            |                          |            |                       |                  |  |            |
| ਹੈ ਛੋਵ <b>ਿ</b> .   | edical                | UNPENDED  | AMENDED                            | )                              |                           |          |                                       |                    |            |                          |            |                       |                  |  |            |
| 760,<br>ficate be ex<br>g physician<br>the burial   | ≥ ا≥                  | IF FEMALE:<br>3b. Was decedent pregnant in the  |                                    | s, outcome of p                |                           | F-4-1    | J                                     | Ectopic            | o prognan  | 101/                     | 2          | 23d. Date of<br>Month |                  |  | /eaг       |
| certif  | l a                   | past 12 months?   | Live                               | gnant at time of               | 2<br>f death 5            |          | (Specify)                             |                    | c pregnan  | icy                      |            | WOTH                  |                  | ay   | Cui        |
| Box 687 The death certific the attending produce as the   | Physician             | 1 Yes 2 No 9 Uni  | known g Unk                        | nown                           |                           | 0.1101   | (=,,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,-,- |                    |            |                          |            |                       |                  |  |            |
| P.O. s that the gned by t   |                       | Part II. Other significant condit   | tions contributing                 | to death but no                | ot resulting in th        | e und    | erlying cause                         | given in Pa        | art I.     |                          |            |                       |                  | the cause of d                                   |            |
| S, P.C.   | g<br>D                | Chronic Alcoholism  |                                    |                                |                           |          |                                       |                    |            |                          |            |                       |                  | ably 4 🗸 U                                       |            |
| v request should  | Completed             | -   |                                    |                                |                           |          |                                       |                    |            |                          | opsy       | р                     | nor to c         | topsy findings<br>ompletion of c                 |            |
| (eco  | <u></u>               |   | _                                  |                                |                           |          |                                       |                    |            | per<br>1 <b>✓</b> Yes    | formed     |                       | eath?<br>✓ Ye    | s 2  | No         |
| tal Rec   | o l                   | 25. Was case referred to medica   |                                    |                                | V-2 V                     |          | 26.Plac                               | e of Death         | (Check o   | nly one)                 |            |                       | _                |  |            |
| Vita<br>hysici<br>His c   | 9                     | examiner? 1  Yes 2 No   | Hospital: 1                        | Inpatient 2                    | ✓ ER/Outpatie             |          |                                       | Other <sub>4</sub> |            | Home 5                   |            | idence 6              | Other            | :  |            |
| n of \ding Phy.   | <u> </u>              | 27. Manner of Death  1 ✓ Natural 5 Pen  | (Mor                               | te of Injury<br>nth, Day,Year) | 28b. Time o               | of Inju  |                                       | ury at Work        | . I        | 28d. Describ             | e how      | injury occurr         | ed               |  |            |
| sior<br>ttend<br>death<br>death<br>y the  | Ĭ                     |   | stigation                          |                                |                           |          |                                       | Yes 2              |            |                          | 10.        |                       |                  |  | has City   |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic proprietely filled in by the funeral director. | Certification:        | dete  | Id not be 28e. Plantined (Specific |                                | At home, farm, si         | treet, f | actory, office                        | building, e        | tc.        | 28f. Location<br>or Town |            |                       | er or Ru         | ral Route Num                                    | iber, City |
| lospit<br>4 hour<br>3 uners   |                       | 4 Homicide 29a. Certifying P  | hysician: To the b                 | · ·                            | ledge death oc            | currec   | at the time of                        | date and pla       | ace, and   | due to the ca            | use(s)     | and manner            | as state         | ed.  |            |
| To the Hos<br>within 24 h<br>To the Fur<br>completely   | Medical               | (Check only one) 2 Medical Exa  | miner: On the basi                 | s of examination               | on and/or investi         | gation   | , in my opinio                        | n, death o         | courred at | the time, da             | te and     | place, and d          | ue to th         | e cause(s)                                       |            |
| \$ \$ \$ \$ \$ \$ \$ \$   | ĕŀ                    | 29b. Signature and title of certific  | and manne                          | Stated                         |                           |          | 29c. Licen                            | se number          |            |                          | 29         | d. Date sign          | ed (Moi          | nth, Day, Year)                                  |            |
|   | 1                     | V Color   | lill                               | 0/)                            |                           |          | 0.0                                   | .M.E.              |            |                          | M          | lay 23, 20            | 80               |  |            |
|   | +                     | 30. Name and address of person  | who completed ca                   | ause of death (I               |                           |          |                                       |                    |            |                          |            |                       |                  |  |            |
| ng XI   |                       | Laron Locke MD. A   | Assistant Medic                    |                                |                           | nn S     | treet, Balti                          | imore, N           | 1D 2120    | 01                       |            |                       |                  |  |            |
| Sta   | ~                     | 31. Date filed (Month, Day, Year)   | 2008                               | Registrar's Sigi               | nature                    | -19      |                                       |                    |            |                          |            |                       |                  |  |            |
| Registr   | _                     | MIMI & O  | 2000                               | Color A                        | T AND                     | W.       | ,                                     |                    |            |                          | -          |                       |                  |  |            |
| DHMH 17 Rev 1/200   | 11                    | 00:4=   |                                    |                                | ÖRIGIN                    | IAL      |                                       |                    |            |                          |            |                       |                  |  |            |

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 05 Day 24 12:15 PM LOUIS F. FRAZETTI 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1210 Farmview Road Pasadena Anne Arundel Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 5. Social Security Number **Funeral** Hours Months Days 86 218-01-9595 Director Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the two diest Evaminer must be notified at Be Completed by Funeral Director 1 ☐ Yes 2 🛂 🗖 o MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 Farmview Road 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify 3 ■ Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Barber Shop Barber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Health and Mental tem 27 is marked o Joseph Frazetti Frances Monti မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jim Frazetti / Son 8006 Horicon Pt. Dr., Millersville, MD 21108 permit. Pages 1 and Department of Heali Important: If item 2 any Injury or other 20a. Method of Disposition Entombment

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 4 ☐ Donation 5 ☑Other (Specify) Glen Haven Mem Pk 05/29/08 Glen Burnie, MD 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 21. Signature of Funeral Service Licensee 169 Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final cancer colorectal **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 📉 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Bestgate Rd. Annapolis, Md. 21401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Selonich, no 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

8 2008

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc 2879 5-28-08 vt.
State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 7:21 AM FIELDS 13 21 2008 CLARENCE MA /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, tOSPITAL SECOURS BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Year) **Funeral** Months Days 216-34-408 1 X M 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 1 Yes 2 No altimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. 14. Race Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: 2 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) onstructi prick Layer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Williams relas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print, W. Ostend St. WIFE xelatha lto. Md. 21230 20b. Place of Disposition (Name of cemetery, crematory or other place Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) -27-08 5 22. Name and Address of Facility 21. Signature of Funeral Service Licens 21229 fit. march Jar in Assease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate ause (Final disease or condition resulting in death) holangiocurcinoma Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. attending physician for use as the buria Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Month Year in the past 12 months? Dav signed by the a 1 Yes 2 No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy has 22 No certificate 1□ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Sentence 6 Other (Specify) : After this of funeral dire 1 Yes 2 No 1 🔲 Inpatient 2XER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? I Director: After to d in by the funera 27. Manner of Death 5 ☐ Pending investigation Injury 1. Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D40854 2008

Registrar

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30. Name and address of page n who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year) MAY 2 8

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 For State Registrar Amend #1,perMD,C879 5/29/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** Leon Faust, Jr. 2008 Tay 26 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL Randalls town Balti more orth WEST If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) 6. Sex 7. Age fin yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months 12 M 2 F Director Washington Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Denmark 1 Yes 2 No Director Carolina 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 2 9042 798 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) John Hopkin Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. echnicar puter Kesea permit. Pages 1 and 2 should be filed i Department of Health and Mental Hygic Important: If item 27 is marked other t any injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sade -aust Yle R ပ 0/ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Plant Rd WIFE EVON 1798 South Faust 29042 Denmark arolina 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 3 ☐ Removal from State 6-6-08 Denmark. 21. Storpture of Funeral Service Licensee 22. Name and Address of Facility m. Wallace Nancy se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest List only one cause on each line. 23a. Part1. Enter the disc shock, or heart faily Immediate Cause (Findisease or condition resulting in death) **Physician** Sepsis /Medical Due to ( as a consequence of): **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be executed burial-transi and Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. be detached 9 Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 donknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1∐ Yes 2☑No 2 NO Division or Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 | Yes 2 | No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA After this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 ANatural To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🗹 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day,

arrou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Coul

oad, Randallstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day DONALD RAYMOND **FARBER** 2008 1:45P MAY 26 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE STELLA MARIS HOSPICE TIMONIUM Date of Birth Month Day Year 29 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 78 214-26-4118 Director Usual Residence of Decedent 3 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, if a Madical Examination insite to notified at Director 1 Nes 2 No N/A BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3925 BEECH AVENUE 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 7 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married WHITE If Yes, Give Year or Dates: 1 Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. land 2121 College (1-4or 5+) Elementary/Secondary (0-12) STOCKBROKER INVESTMENT permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event one. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SAMUEL **FARBER** RUTH BRAVE ၉ Itimore, Mary 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2305 CANYON DRIVE, LOS ANGELES, CA 90068 DELPHINE HIRSH / NIECE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BETH TFILOH CONG. 05/27/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RIDMUOSAICOMO weeks /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, feating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) the burial-transit resulting in death) Last Due to (or as a consequence of) physician IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy cate has been signed by the atternate page 2 should be detached for Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an this certificate has autopsy 2 **X**No 1 ☐ Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Timonium MD 21093 Wright 2300, Dulaney Valley Proestine

State Registrar 31. Date filed (Month, Day,

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Division of Vital Records, P.O.

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician U. Grissett Evelyn 2008 15:05 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 4c. County of Death Examiner 861 Lenton Ave 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** 1 □ M 2 🖵 F Months Days Hours Min. Director 213-52-2982 0111 MD 61 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location show 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Director ty∑Yes 2 ☐ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. Funeral 861 Lenton Ave 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes Y☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16b. Kind of Business/Industry,
Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary Public School 12th grade permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygic Important: If item 27 Is marked other i any Injury or other traumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Milton Myers Jr. Elizabeth Urguhart 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 Raymond Grissett-Husband 861 Lenton Ave, Baltimore, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn 5/30/08 Baltimore Co, Md 21. Signatul of Funeral Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) Ventricular technicula **Physician** /Medical Due to (or as a consequence of): Examiner Cordiany part Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and requires that the death certificate be exec Due to (or as a consequence of): burial-1 Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a 5 ☐ Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas page 2 s autopsy performed 2 No 1 Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending n 24 hours after death.

Ne Funeral Director: A pletely filled in by the fu death. investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٥

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7602

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death GOODMAN Month Year 2008 **Physician** ATHANIEL /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Northwest Hosp Roudaustown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 250.16.4899 1 XM 2□ F 86 Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at Baltimone Baltimore 1 ☐ Yes 2 No MD Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Drive 21207 Elba "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) grade aborer Compan 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Goodman ပ 19a. Informant' Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown MD 21133 Road Foster Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Windsor Mill, MD 05/29/08 Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Vaughn C. Breene Funeral Services 8728 Liberty Road Randalbtown MD 21133 uch as cardiac or respiratory arrest, 23a. Part1. Ent of the disease, or complications that caused the death. Do not enter the mode of dyingshock, or he in failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) □Yes 2□No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ero valcular disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ♣ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No Certification: To 1 patient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 054288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) anour 37 Registrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

DHMH 17 Rev 1/2001

MAY 2 8 2008

08-03603 Bernard Graham

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

17174 2008

|  | 1- For State Registrar   |                                      | Certin                         | ficate of                       | Death                           |                                |                                     | Reg. N                    | 10.                     | 00 1                                       | 7 1 7 5                   |
|--|--|--------------------------------------|--------------------------------|---------------------------------|---------------------------------|--------------------------------|-------------------------------------|---------------------------|-------------------------|--|---------------------------|
| Physician/   | Decedent's Name (First, Mid                                    | dle,Last)                            |                                |                                 |                                 |                                | 2. Date<br>Mon                      | of Death<br>th Da         | v Year                  | 3. Time of De                              |                           |
| ledical Examiner   | Deliala olai   |                                      |                                |                                 |                                 |                                | May                                 | 11, 2008                  | 3                       | 0948 hrs                                   | ·                         |
| str.   | 4a. Facility Name (if not institut                             |                                      | mber)                          | 4                               |                                 | or Location o                  | f Death                             |                           | 4c. County of D         | eath                                       |                           |
|  | 400 Block West Sar   |                                      |                                |                                 | Baltimore                       |                                | ani la n                            | to of Diet (              | a uppaggard a           | Bidhalasa (State                           | or 1                      |
| Funeral  | 5. Social Security Number un                                   | 1 6. Sex                             | 7. Age (In yrs. last           | t birthday)                     | If Under 1 Y                    | ear If Unde<br>ays Hours       | Min                                 |                           | jF:                     | . Birthplace (State oreign                 | unk                       |
| Director   |  | 1 XM 2 F                             | 52                             | Yrs.                            | Wioritins                       | ays Hours                      | No                                  | v 29,                     | 1955                    | Country)                                   |                           |
|  | Usual Residence of Decedent                                    |                                      |                                |                                 |                                 |                                |                                     |                           |                         | 10d. Inside C                              | ity Limits                |
| v any  | 10a. State 10b. Count  | У                                    | 10c. City, 10                  | own or Location                 |                                 |                                |                                     |                           |                         | 1 X Yes                                    | · 1                       |
| Maryland<br>28a-f show<br>1 at once.<br>ector  | MD Bal   | timore                               |                                | Gwyni                           | n Oak                           |                                |                                     | 120                       | Citizen of What         | 21   |                           |
| the Maryland tor 28a-f shiffied at one   | 10e. Street and Number   | _                                    |                                |                                 | 10f. Zip Cod                    |                                |                                     | 10g.                      | Citizen of What<br>USA  | •  | l                         |
| 34 or otifie   | 2121 Windsor   | 1                                    |                                |                                 |                                 | 21207                          |                                     |                           |                         |  |                           |
| or items 23<br>must be no<br>Funeral   | 11. Marital Status   | Armod E                              | edent Ever in U.S.<br>prces?un |                                 | s Decedent of<br>es, specify Cu | Hispanic Orig<br>ban, Mexican, | gin? ( Specify Y<br>, Puerto Rican, | es or No-<br>etc.)        | White, e                | American Indian, Bl<br>etc.                | ack,                      |
| or ite   | 1 Never Married 2  | 1 Yes                                | 2 No                           |                                 | Yes 2 X                         |                                |                                     |                           | Specify:                | black                                      | 1                         |
| s after raf", niner  | Widowed 4  | Divorced If Yes, Give Year or Dates: | r                              |                                 |                                 |                                |                                     | neunk 16                  | b. Kind of Busin        | ess/Industry                               | unk                       |
| 5-0036<br>ed within 72 hour<br>lygiene.<br>other than "natu<br>he Medical Exan<br>Completed  | 15. Decedent's Education (S<br>Elementary/Secondary (0-1       |                                      |                                | during mo                       | ost of working                  | life. DO NOT                   | use retired)                        |                           |                         |  |                           |
| 36<br>iin 72<br>han dical  | unk  | unk                                  | 10.0.7                         |                                 |                                 |                                |                                     |                           |                         |  |                           |
| 5-0036 led within 7 tygiene. other than the Medica   | 17. Father's Name (First, Midd                                 | la, Last)                            |                                |                                 | unk                             | 18.Mother                      | 's Name (First,                     | Middle, Mai               | den Surname)            |  | unk                       |
| al Hy sed of at, the C   | , <del> </del>   |                                      |                                |                                 |                                 |                                |                                     |                           |                         |  |                           |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than e event, the Medica To Be Comple  |  | nship (Type, Print)                  |                                | 1                               |                                 |                                |                                     |                           |                         | State, Zip Code)                           |                           |
| MD 21215-0036 a 2 should be filed within 72 hours after death with the Maryland lith and Mental Hygiene. m 27 is marked other than "natural"; or items 23n or 28n-f she anmatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director   | O.C.M.E.   |                                      | 17                             | 111 1                           | Penn S                          | treet I                        | Baltimo                             |                           |                         |  |                           |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: If item 27 is marked other than "natural", or items 23s or 28s-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director   | 20a. Method of Disposition                                     |                                      |                                | ace of Dispos<br>ematory or oth |                                 | f cemetery,                    | Date                                | 2                         | 0c. Location - C        | ity or Town, State                         |                           |
| nor<br>ages<br>ant of<br>nt: If  | 1 Burial 2 Cremat 4 Conation 5 X Other                         |                                      | OIII State                     | oa.c., c. c                     | , <b>F</b> ,                    | ,                              |                                     |                           |                         |  | ļ                         |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other thinjury or other traumatic event, the Med Traum | 4 Conation 5 A Other 21. Signat re of Fun. 1 Sang Ronal        |                                      |                                | 22+N                            | lame and Add                    | ress of Facilit                | Soard 6                             | 55 W.                     | Baltimo                 | re Stree                                   | ŧ ]                       |
| Dep Dep In Injury  | Konato   | may wade,                            | Legion                         | Ba                              | ltimor                          | MD_                            | 21201                               |                           |                         |  |                           |
| Physician  | 23a. Part I. Enter the disease, failure. List only one cau     | or complications that o              | aused the death. [             | Do not enter ti                 | he mode of dy                   | ing, such as o                 | cardiac or respi                    | ratory arrest             | , shock, or hear        | Approxima<br>Between                       | nte Interval<br>Onset and |
| Medical<br>* Examiner  | Immediate Cause (Final disea                                   | A ambunda b                          | y hanging                      |                                 |                                 |                                |                                     |                           |                         | De   | eath                      |
| xaminer  | or condition resulting in death                                |                                      | a consequence of)              | •                               |                                 |                                |                                     |                           |                         |  |                           |
| _  | Sequentially list conditions,                                  | b                                    |                                |                                 |                                 |                                | _                                   | _                         |                         |  |                           |
| led Insit  | if any, leading to immediate<br>cause. Enter Underlying Cau    | Sec C                                | a consequence of)              | :                               |                                 |                                |                                     |                           |                         |  |                           |
| T E  | (Disease or injury that initiate events resulting in death) La | u <del></del>                        | a consequence of)              | :                               |                                 |                                |                                     |                           |                         |  |                           |
|  |  | d                                    |                                |                                 |                                 |                                |                                     | <del></del>               |                         |  |                           |
| 0 7 7 7  | UNPENDED   | AMENDED                              |                                |                                 |                                 |                                |                                     |                           |                         |  |                           |
| .760, icate be execut by sician and the burial - tra   | IF FEMALE:<br>23b. Was decedent pregnant i                     |                                      | outcome of pregn               |                                 |                                 | 0 -                            | fo                                  |                           | 23d. Date of d<br>Month | elivery<br>Dav                             | Year                      |
| Sox 68's leath certification of for use as invisional  | past 12 months?  | 1                                    | birth<br>nant at time of dea   | 46                              | etal death<br>ther (Specify)    |                                | ic pregnancy                        |                           | Monar                   | 20,  |                           |
| the death certiful the death certiful the death certiful to the attending the death of the asset of the death of the asset of the death | 1 Yes 2 No 9   | Unknown g Unkr                       |                                | 3 0                             | mer (opeary)                    |                                |                                     |                           |                         |  |                           |
| O. B nat the day the etached or Phy  |  | nditions contributing                | to death but not re            | sulting in the                  | underlying ca                   | use given in P                 | Part I.                             |                           |                         | ute to the cause of                        |                           |
| res that the signed by be detach   |  |                                      |                                |                                 |                                 |                                |                                     | 1 Yes                     | 2 V No 3                | Probably 4                                 | Unknown                   |
| Records, The law requires ficate has been signated about the basen signated by the completed the second bear and the completed the second bear and |  |                                      | -                              |                                 |                                 |                                | F                                   | 24a. Was an               |                         | ere autopsy finding<br>for to completion o | s available f cause of    |
| COF<br>law I<br>has t  |  |                                      |                                |                                 |                                 |                                |                                     | perform  Yes 2            | ed? de                  | eath?  Yes 2                               | No                        |
| tal Rection: The certificate ector, page   | OF Man area referred to mor                                    | lingt                                | <del></del>                    |                                 | 26.1                            | Place of Death                 | n (Check only o                     |                           | 110                     | 7 703 2                                    |                           |
| Division of Vital Records, tal or Attending Physician: The law requir its after death.  al Director: After this certificate has been silled in by the funeral director, page 2 should the fifter at the Committee of the control of the committee.   | 25. Was case referred to med examiner?                         | Hospital:                            | Inpatient 2                    | ER/Outpatien                    |                                 | Other:                         | Nursing Hor                         |                           | esidence 6              | Other: Scene                               |                           |
| of Vi  |  | 28a. Date                            | e of Injury                    | 28b. Time of                    |                                 | . Injury at Wo                 | rk? 28d.                            | Describe ho               | w injury occurre        | ıd   |                           |
| nding Ph<br>nding Ph<br>th.<br>:: After t<br>e funeral   | 1 Natural 5 F  | Pending FOUN                         | th Day,Year)                   | FOUND:                          | 1                               | Yes 2 ▼                        | No Sub                              | ject hang                 | ed self                 |  |                           |
| Sior<br>Attend<br>r death<br>ector:<br>by the  | 2 Accident   | nvestigation May 11<br>28e. Pla      | , 2008<br>ce of Injury - At ho | 0940 hrs<br>me, farm, stre      | et, factory, of                 | fice building,                 | etc. 28f.                           | Location (St              | reet and Numbe          | r or Rural Route N                         | umber, City               |
| Division os spiral or Attending spiral or Attending lours after death.  filled in by the function:   | 3 ✓ Suicide 6 0  | Joula not be                         | Alley                          |                                 |                                 |                                | 400                                 | or Town, Sta<br>Block Wes | ite)<br>t Saratoga Str  | eet, Baltimore, N                          | <b>N</b> D                |
| lospit<br>I boun   |  | a Physician: To the he               | et of my knowledg              | e. death occu                   | irred at the tin                | ne, date and p                 | blace, and due t                    | to the cause              | (s) and manner          | as stated.                                 |                           |
| Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as Madical Contification: To Be Completed by Physician   | (Check only one) 2 Medical                                     | Examiner: On the basis<br>and manner | of examination ar              | nd/or investiga                 | ation, in my or                 | inion, death o                 | occurred at the                     | time, date a              | nd place, and du        | ie to the cause(s)                         |                           |
| To roo   | 29b. Signature and title of ce                                 |                                      | stated.                        |                                 | 29c. L                          | icense numbe                   | er                                  |                           | 29d. Date signe         | ed (Month, Day, Ye                         | ar)                       |
|  | 1 Colons   | 11.5                                 | 7/                             |                                 |                                 | D.C.M.E.                       |                                     |                           | May 12, 20              | 38   |                           |
|  | 30. Name and address of per                                    | rson who completed cal               | use of death (Item             | 2 a)                            |                                 |                                |                                     |                           |                         |  |                           |
|  | Zabiullah Ali, M.D.  | Assistant Medi                       |                                |                                 | nn Street,                      | Baltimore,                     | MD 21201                            |                           |                         |  |                           |
| Stat   | a 31. Date filed (Month, Day, Ye                               |                                      | Ragistrar's Signatu            | ire                             |                                 |                                |                                     |                           |                         |  |                           |
| Registra   | 8871/  | 2 8 2008                             | Ungres ,                       | B. A.                           | rectify.                        |                                |                                     | 00                        | ME                      |  |                           |
| DHMH 17 Rev 1/200  | 1  |                                      |                                | ORIGIN                          | AL                              |                                |                                     | -                         |                         |  |                           |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12 30g **Physician** Gardner Mary E. 09 2008 05 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Brightwood Baltimore Lutherville Genesis f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Apr 7, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 □ M 2 🔀 F 90 Ohio Director 269-01-9973 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ir than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MD Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 USA 545 Brightfield Road 2 should be filed within 72 hours after death v n and Mental Hygiene. Is marked other than "natural", or Items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: white þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 0 housewife own home permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: if Item 27 is marked other any injury or other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clarence Mullinix Clara Landwehr 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucy Gardner/daughter 6303 Leafy Screen Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service State Anatomy Board 655 W. Baltimore Street Director nn Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dementia /Medical Due to (or as a consequence of): **Examiner** Arterio sclerosis Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown mellitus type 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 24a, Was an Hypertension autopsy performed 2 No 2 NO 1∐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 🗜 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

State Registrar

Laura M Mumford 31. Date filed (Month, Day, Year) MAY 2 8 2008

ama M Muse

30. Name and address of person who completed oduse of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

MP 10755 2. Registrar's Signature

00018410

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydien 2008

17176

| 2 Deceaded Name (First Methods Last)   3 Deceaded Name   20 Deceaded   |       |  | - 1       | For<br>State<br>Registrar  | State of Mary                             | C                              | ertificate of                                    | Death                                    |                                       | Reg. No.   |                                 |
|--|-------|--|-----------|--|---|--------------------------------|--|--|---------------------------------------|--|---------------------------------|
| Part      |       |  |           |  | )   |                                |  |  |                                       | Day Your   |                                 |
| Security Process of Pr |       |  |           | Marjorie Agnes Gr  | aham                                      |                                |  |  | May 2                                 |  |                                 |
| S.S. Catherine Number 6 Sur 17 Age on my superior or control 18 Cours of Sur 1 |       |  |           | a. Facility Name (If not institution, give                       | street and number)                        |                                |  |  |                                       |  |                                 |
| USE A CONTROL OF THE PROPERTY  |       |  |           | St. Catherine Nur  | sing Cente                                | r<br>n vrs last hirtho         |  |  | 8. Date of Bi                         |  |                                 |
| Use Section of Decision of Decision of Decision of Decision of Management of Decision of Management of Decision of Management of Decision of Management of Decision of Management of Decision of Decision of Management of Decision of Management of Decision of Decision of Management of Decision of Management of Decision of Decision of Management of Decision of Management of Decision of Decision of Management of Decision of Management of Decision of Decision of Management of Decision of Management of Decision of Decision of Management of Decision of Decisio |       |  |           |  | _м <del>20</del> г                        |                                |  | Hours Min.                               | Jan 16                                |  |                                 |
| Sewerates Office of the Color   |       |  |           | Usual Residence of Decedent                                      |   |                                |  |  |                                       |  |                                 |
| Sewerates Office of the Color   |       | Marylan  | tor       |  |   |                                |  |  |                                       |  | YY                              |
| Sewerates Office of the Color   |       | n with the   | al Direc  |  |   |                                |  |  |                                       | _  | Country?                        |
| Sewerates Office of the Color   | 936   | urs after deatl                                      | þ         | 1 Never Married 2 Married  | Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give | er in U.S.                     |  |  | ecify Yes or N<br>Rican, etc.)        |  | nite, etc.                      |
| Sewerates Office of the Color   | 9-0   | 72 hou   | ted       | 15. Decedent's Edi   | ucation                                   | 16a. D                         | ecedent's Usual Occup                            | pation<br>during most of work            | king                                  | 16b. Kind of Busines   | ss/Industry                     |
| Pursician   Purs   | 21    | ithin ite.   | npie      |  |   |                                |  |  |                                       | Insura   | nce                             |
| Continued by State   Continu   |       | iled w<br>tygier<br>ther th                          |           |  |   | Au                             | miritizo di acr                                  |  |                                       |  |                                 |
| Continued by State   Continu   | and   | d be f   | ) Be      |  | 17  |                                |  | Helen A                                  | inshor                                | nueh   |                                 |
| Continued by State   Continu   | Z     | should<br>nd Me<br>mark<br>mati                      | F         |  |   | 19b. A                         | failing Address (Street                          |  |                                       |  | , Zip Code)                     |
| Continued by State   Continu   |       | nd 2<br>alth al<br>27 is<br>r trat                   |           | Regina G. Hartlove   | e (Daughter                               | 503                            | 4 Kemp Rd.                                       | Reisters                                 | town, 1                               | MD 21136   |                                 |
| Physician / Medical Examiner    Approximate   Physician / Medical Examiner   Physician / Medical Examiner   Physician / Physician / Physician / Medical Examiner   Physician / | more, | Pages 1 a<br>ent of Hei<br>nt: If item<br>ry or othe |           | 20a. Method of Disposition  2 △ ABurial 2 □ Cremation 3 □        | Removal from State                        | 20b. Place of D                | crematory or other pla                           | ce)                                      |                                       | la contract of the contract of |                                 |
| Physician (Medical Examiner)  Physic | Balti | permit. Departm Importa any inju                     | Ì         | 2). Signature of Fulleral 2 rvice Lieu                           | Le  |                                |  |  | s, MD 21117                           |  |                                 |
| Physician / Medical Examiner    Female          |  |           | 2sa. Part. Enter the disease, or comp                            | dications that caused the                 |                                |  |  |                                       |  | Approximate<br>Interval Between |
| Proposed and state of the state |       | Physician  |           | Immediate Cause (Final   | Foiler                                    | e to                           | This   | e  |                                       |  | 6 Lyou /L                       |
| Sequentially list conditions.  Sequentially list conditions.  Sequentially list conditions.  Sequentially list conditions.  Due to (or as a consequence of):    Conditions   C |       | /Medical   |           | resulting in death)  | Due to (or as a c                         | consequence of                 | : /  | 0 0                                      | 3                                     |  | 7                               |
| The final midated events resulting in death) Last    Composition of the composition of th | п     | Examiner   |           | Sequentially list conditions,                                    | b. Soux                                   | 10 91                          | 25 Tra   | faces                                    | 3                                     |  | 6 luculo                        |
| The final midated events resulting in death) Last    Composition of the composition of th | 1     | ed sit   | ine       | if any, leading to immediate cause. Enter Underlying             | A H                                       | consequence of                 | 2  | 3 5                                      | esta                                  | 00   | 14001                           |
| FFEMALE:   23c. If yes, outcome of pregnancy   1   1   1   1   1   1   1   1   1   | y"    | xecut<br>and   | хап       | that initiated events  | c. Due to (or as a c                      | consequence of                 | i caja   | o Mo                                     | 2)                                    | )  |                                 |
| FFEMALE   23b. Was decedent pregnant in the past 12 months?   1   Yes   2   No   2   Festal death   1   Yes   2   No   3   Frobably 4   Unknown   1   Yes   2   No   No  | 09    | sician<br>buriz                                      | aiE       |  | 1 Hoer                                    | Ten                            | Sive,  | 10100                                    | la                                    | d 3 005.   | e 25 yr 8                       |
| 24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes   2   No   25c. Place of Death   1   Yes   25c. Place of Death   1   Yes   2   No   25c. Place of Death   1   Yes   25c. Place of Death   1   Yes   2   No   25c. Place of Death   1   Yes   2   No   25c. Place of Death   1   Yes   2   No   25c.    | 687   | ificate<br>g phys<br>as the                          |           |  | 0. 1. 11                                  | 1                              |  |  |                                       |  | (                               |
| 24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes   2   No   25c. Place of Death   1   Yes   25c. Place of Death   1   Yes   2   No   25c. Place of Death   1   Yes   25c. Place of Death   1   Yes   2   No   25c. Place of Death   1   Yes   2   No   25c. Place of Death   1   Yes   2   No   25c.    |       | he death cert<br>the attending                       | ysician/M | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No | 1 Live birth 2<br>4 Pregnant at tir       | Fetal death                    |  | y  |                                       |  |                                 |
| 24a. Was an autopsy performed?   24b. Were autopsy findings available prior to completion of cause of death?   1   Yes   2   No   25c. Place of Death (Check only one)   25c. Manner of Death   1   Nursing Home   5   Residence   6   Other (Specify)   25c. Number of Rural Route Number, and manner stated.   25c. Clark of the state and place, and due to the cause(s) and manner stated.   25c. Clark of the state and place, and due to the cause(s)   25c. Clark o   |       | that<br>hed by<br>deta                               | y Ph      | Part II. Other significant conditions of                         | ontributing to death but                  | not resulting in t             | he underlying cause g                            | ven in Part I.                           | 23e. Dio                              | tobacco use contribute   | e to the cause of death?        |
| The particular of the particul | rds   | quires<br>in sign                                    | q pa      | Valcala  | - dan                                     | ear T                          | à  |  | 1                                     | Yes 2 No 3   | Probably 4 Unknown              |
| Solution   Street and Number of Rural Route Number,   Street   S   | Reco  | he law rec<br>e has bee<br>ige 2 shor                | mpiet     | for ma,  | 'OR ST                                    | rdes                           | 2 155  | 5  | au                                    | topsy prior<br>formed? death   | to completion of cause of       |
| Solution   Street and Number of Rural Route Number,   Street   S   | tal   | an: T<br>tificat<br>tor, pa                          | a)        |  |   |                                |  | 26. Place of Dea                         |                                       | 7  |                                 |
| Solution   Street and Number of Rural Route Number,   Street   S   | ΓV    | ysicii<br>is cer<br>direct                           |           |  | Hospital: 1   Inpatient                   | 2 ER/Outp                      | eatient 3 DOA                                    | her: 4 Nursing H                         | lome 5 Re                             | sidence 6 Other (S   | (pecify)                        |
| 2   Accident 3   Suicide 4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number, City or Town, State)   29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   3   | 0 1   |  |           | N:   | 28a. Date of Injury<br>(Month, Day )      |                                | ne of 28c. Inju                                  | ork?                                     | 28d. Describ                          | e how injury occurred  |                                 |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)   | Sio   | eath.<br>or: A                                       | catic     | 2 Accident investigation   |   |                                | 206 Location                                     | (Circut and Number of                    | r Dural Poute Number                  |  |                                 |
| 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)   | Divi  | s after d  | Certifi   | determined   | 286. Place of injury                      | y - At home, tarr<br>(Specify) | n, street, factory, office                       |  | City or 1                             | Town, State)   | Autai Auta Autabat,             |
| Donger (Cramper for Cayle) (1909 4443) May 25, 200   |       | ne Hospi<br>n 24 hour<br>ne Funer<br>pletely fills   | edicai    | (Check only 2 Medical Exan                                       | niner: On the basis of e                  | xamination and                 | death occurred at the to or investigation, in my | time, date and place opinion, death occu | e, and due to the<br>irred at the tim | e, date and place, and   | due to the cause(s)             |
| Dought Crawfer for Caylo Home 220 Type Print)  |       | To the To the Comp                                   | Ž         | 29b. Signature and title of certifier                            |   | D. 15                          | 29c. Licer                                       | ise number                               | > 1.                                  | 29d. Date signed (M  | onth, Day, Year)                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eugin 75519, WD 71551   |       |  |           | Dondark  | rougel                                    | 101/0                          | 40 140   | 2440.5                                   | 2                                     | may 2  | 5, 200                          |
| 121-123 (1) Maia STASET REGLICIETTYSHURA   |       | 5  |           | 30. Name and address of person who $121-03$ (1).                 | completed cause of dea                    | ath (Item 23a) (T              | ype, Print)<br>Thear                             | Emi                                      | 15tha                                 | Sig, u   | (2412, QV                       |
| State  State  31. Date filed (Month, Day, Year)  Registrar's Signature   |       |  |           | 31. Date filed (Month, Day, Year)                                | A. Registrar                              | 's Signature                   | Cook o   |  | (                                     |  |                                 |

|            |   |                | For<br>State<br>Registrar  | State of Mar  | yland /                |                            | tment of<br>ificate o                     |                              |                                 | ntal Hy                       | giene<br>Reg. No          | 8008  | 171   | 77            |
|------------|---|----------------|--|---|------------------------|----------------------------|---|------------------------------|---------------------------------|-------------------------------|---------------------------|---|---|---------------|
| 鬱          | Physicia  |                | 1. Decedent's Name (First, Middle, Last)   |   |                        |                            |   |                              |                                 | Date of De<br>Month           | Day                       | Year  | 3. Time of D                                |               |
|            | /Medic  | al             | Allen R. Greene  |   |                        |                            | 41 O'T T                                  |                              |                                 | May                           | 21                        | 2008<br>County of Death                           | 5:13  | P™            |
|            | Examin  | er             | 4a. Facility Name (If not institution, give the Laurel Regional  |   |                        |                            | 4b. City, Town<br><b>Lau</b> 1            |                              | 1 of Death                      |                               |                           | rince Ge  | eorge's                                     | <b>,</b>      |
|            | Funeral   |                | 5, Social Security Number 6. Sec   | 7. Age  | (In yrs. last i        | birthday)                  | If Under 1 Yes                            | ar If Unde                   |                                 | Date of Bir<br>(Month, Da     | th                        |   | lace (State or                              |               |
|            | Director  |                | 216-28-6171  | <b>X</b> M 2□F  | 77                     | Yrs.                       | Months Day                                | is Hours                     |                                 | May 2                         |                           |   | land  |               |
|            | and<br>w  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, To          | own or Loca                | ation                                     |                              |                                 |                               |                           | 1   | 0d. Inside City                             | / Limits      |
|            | Maryla<br>f sho<br>ied at   | ō              | Maryland Howard  |   |                        | Co                         | lumbia                                    |                              |                                 |                               |                           |   | 1 ☐ Yes                                     | 2 <b>Z</b> No |
|            | r 28a-  | Directo        | 10e. Street and Number   |   |                        |                            | 10f. Zip Code                             | Э                            |                                 |                               | 10g. Citize               | en of What Cour                                   | ntry?                                       |               |
|            | th witl<br>23a o<br>ust be  |                | 9334 Big River Ru  | n Court   |                        |                            |   | 2104                         |                                 |                               |                           | U.S.A.  |   |               |
| 36         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent Ev<br>Armed Forces?<br>1 ▼Yes 2 No<br>If Yes, Give<br>Year or Dates: |                        |                            | as Decedent of Yes, specify C             |                              |                                 | y Yes or No<br>can, etc.)     |                           | 4. Race - Americ<br>Black, White,<br>Specify: Bla |   |               |
| 21215-0036 | 2 hou<br>latura<br>ical E   | ted            | 15. Decedent's Edu<br>(Specify only highest grad   | ication   | 10                     | 6a. Decede                 | ent's Usual Oci<br>ind of work do         | cupation                     | ost of working                  |                               | 16b. Kin                  | d of Business/In                                  | dustry                                      |               |
| 215        | thin 7<br>ie.<br>ian "n<br>Medi:  | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+   | )                      | life. D                    | O NOT use ret<br>Force                    | ired)                        |                                 |                               | II S                      | . Gover   | nment                                       |               |
| 21         | led wi<br>Hygier<br>her th<br>ht, the   | ပိ             | 17. Father's Name (First, Middle, Last)  | ······································  |                        | ATT                        | roice                                     | 18. Mot                      | ther's Name (F                  | irst, Middle                  | L                         |   | Incirc                                      |               |
| Maryland   | the final Head of sed of sever  | Be             | Percy Greene   |   |                        |                            |   | ]                            | rene C                          | ook                           |                           |   |   |               |
| Ž          | should mark mark  | 은              | 19a. Informant's Name/Relationship (T)   | /pe. Print)   | 1                      | 9b. Mailing                | Address (Stre                             | eet and Num                  | nber or Rural F                 | Route Numb                    | er, City or               | Town, State, Zip                                  | Code)                                       |               |
| 2          | alth ar   |                | Shirley Greene (Wi   | fe)   |                        | 9334                       | Big Ri                                    | ver Ru                       | ın Cour                         | t Co                          |                           | a, MD 2   |   |               |
| altimore,  | es 1 a of Heg   |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I  | Domoval from State  | 20b. Place<br>ceme     | e of Dispos<br>etery, crem | ition (Name of<br>atory or other          | place)                       | Dat                             | е                             | 20c. Loc                  | cation - City or To                               | own, State                                  |               |
| Ĕ          | Page<br>ment<br>ant: If<br>ury o  | h:             | 4 □ Donation 5 □ Other (Specify,   |   | Gard                   | ens                        | ition (Name of<br>atory or other<br>Memor | Tar                          | 5-27-                           |                               |                           | iottsvi   | lle, M                                      | )             |
| Balt       | permit. Depart Import any inj   | l III          | 21. Signature of Funeral Service Licens  | Uma   | indu                   | 55                         |   | n Knol                       | lls Roa                         | .d. Co                        | Lumbi                     | a, MD 2   |   |               |
|            |   |                | 23a. Part1. Enter the di ease, or comp<br>shock, or heart failure. List only c   | lications that caused to<br>one cause on each line                                    | the death. De.         | Do not ente                | r the mode of                             | dying, such                  | as cardiac or i                 | respiratory a                 | arrest,                   | 73  | Approximate<br>Interval Betv<br>Onset and D | veen          |
|            | Physician<br>/Medical   |                | Immediate Cause (Final disease or condition resulting in death)  | u   |                        |                            | neumoni                                   | a                            |                                 |                               |                           |   |   |               |
|            | Examiner  |                |  | Due to (or as a   | consequen              | ce ot):                    |   |                              |                                 |                               |                           |   |   |               |
| 2          |   | Je.            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying   | b. Due to (or as a  | consequen              | ce of):                    |   |                              |                                 |                               |                           |   |   |               |
|            | cuted<br>nd<br>ransit   | Examiner       | that initiated events  | c   |                        |                            |   |                              |                                 |                               |                           |   |   |               |
| 3760,      | ate be executed hysician and the burial-transit   | Ex             | resulting in death) Last   | Due to (or as a   | consequen              | ce of):                    |   |                              |                                 |                               |                           |   |   |               |
| 876        | cate b  | dical          |  | d   |                        |                            |   |                              |                                 |                               |                           |   |   |               |
| .O. Box 68 | The law requires that the death certificate has been signed by the attending phoage 2 should be detached for use as it  | Physician/Med  | in the past 12 months?  1 ☐ Yes 2 ☐ No   | 23c. If yes, outcome p<br>1 □ Live birth 2<br>4 □ Pregnant at t<br>9 □ Unknown        | 2 ☐ Fetal de           | ath 3                      | Ectopic pregna<br>Other (specify          |                              |                                 |                               | 2                         | 23d. Date of deliv<br>Month                       |   | ⁄ear          |
| <u>Б</u>   | hat the<br>d by ti<br>letach  |                | 9 ☐ Unknown  Part II. Other significant conditions co  | ontributing to death bu   | t not resultin         | ng in the un               | derlying cause                            | given in Pa                  | art I.                          | 23e. Did                      | tobacco u                 | se contribute to                                  | the cause of d                              | eath?         |
| ds,        | signe<br>d be c   | d by           | , and an end of the en |   |                        |                            |   |                              |                                 | 1 [                           | Yes 2                     | ]No 3∏Pro   | bably 4 🔀                                   | Jnknown       |
| Records,   | w requires been si should I   | Completed      |  |   |                        |                            |   |                              |                                 | 24a. Wa                       |                           | 24b. Were aut                                     | opsy findings                               | available     |
| æ          | The lav   | E G            |  |   |                        |                            |   |                              |                                 | aut<br>per<br>1∏ Yes          | opsy<br>formed?<br>2 X No | prior to c<br>death?<br>1 □ Yes                   | ompletion of ca<br>2 <b>X</b> No            | ause of       |
|            | 10 -  | Be             | 25. Was case referred to medical   |   |                        |                            |   | 26. PI                       | ace of Death                    |                               |                           |   |   |               |
| or Vital   | ding Physician;<br>n.<br>After this certific<br>funeral director,   | To B           | examiner?<br>1 ☐ Yes 2₹□XNo  | Hospital: 1 1 Inpatier  |                        | VOutpatien                 |   |                              |                                 |                               |                           | 6 □Other (Spec                                    | eify)                                       |               |
| n 0        |   |                | 27. Manner of Death 1   ↑ Pending  | 28a. Date of Injur<br>(Month, Day   |                        | 3b. Time of<br>Injury      |   | Injury at<br>Work?           |                                 | 3d. Describe                  | how injur                 | y occurred  |   |               |
| Division   | Attending<br>r death.<br>ector; After   | Certification: | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be  |   | rv - At home           | a farm str                 |   | 1 ☐ Yes 2                    |                                 | 3f. Location                  | (Street an                | d Number or Ru                                    | ral Route Num                               | nber,         |
| Z          | or At<br>after d<br>Direc<br>in by  | ertifi         | 4 Homicide determined  | building, etc   | . (Specify)            | s, iaiii, sii              | ot, idolory, on                           |                              |                                 | City or T                     | own, State                | )   |   |               |
| _          | To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi   | Medical Co     | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exan  | ysician: To the best on<br>niper: On the basis of<br>and manner sta                   | examination            | edge, death<br>n and/or in | occurred at the vestigation, in           | ne time, date<br>my opinion, | e and place, a<br>death occurre | nd due to th<br>d at the time | e cause(s)<br>e, date and | and manner as<br>d place, and due                 | stated.<br>to the cause(s                   | 3)            |
|            | To the I within 2. To the I complet   | Me             | 29b. Signature and title of pertitles  | 2.10  | (                      | •                          | 29c. Lie                                  | cense numb                   | er                              |                               |                           | te signed (Montl                                  |   |               |
|            |   |                | 1////  | avar  |                        | 2                          |   | D6487                        | 4                               |                               | 3/                        | 21/08   | 5   |               |
|            | 141   |                | 30 Narp, and address of person who   | - 1   |                        |                            |   | Dl                           | Cal1                            | · · ·                         | m 21/                     | 244   |   |               |
|            | 211   |                | Shahab Bavahi, M 31. Date filed (Month, Day, Year)   |   | Litt.<br>ar's Signatur |                            | tuxent                                    | PKWY                         | Columb                          | ла, М                         | וא עון                    | J44<br>———————————————————————————————————        |   |               |
|            | St<br>Regist  | ate<br>trar    | MAY 2 8 2  | - 30  |                        |                            | -   |                              |                                 |                               |                           |   |   |               |
| DH         | HMH 17 Rev 1/   |                |  | J. S. B. S. C.  | a B                    | 160                        |   |                              |                                 |                               |                           |   |   |               |
|            |   |                |  |   |                        | OR                         | IGINAL                                    |                              |                                 |                               |                           |   |   |               |
|            |   |                |  |   |                        |                            |   |                              |                                 |                               |                           |   |   |               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:16 A M May 20, 2008 Katherine H. Gibson /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Year)
Oct. 5, 19 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 □ M 2 🗓 F 66 569-54-9323 1941 Director California Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner mast be notified at 1 ☐ Yes 2 No Director Maryland Darnestown Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 14501 Falling Leaf Drive 20878 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examinations. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be Marlin Wallace Halev Mary Elizabeth Woebke ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John E. Gibson/Husband 14501 Falling Leaf Drive, Darnestown, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery 20c. Location - City or Town, State 20a. Method of Disposition May 25. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2008 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Crematoriúm, Inc. 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave.
Rockville, MD 20850 21. Signature of Funeral Service Licensee M01346 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Embolism 1 Hour **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Metastatic Ovarian Cancer 8 Months Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed Ovarian Cancer burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1∐Yes 2∭2No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t page 2 s autopsy performed? certificate 1 ☐Yes 2 ☐ No Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

0,

31. Date filed (Month, Day, Year) MAY 28 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

los a



Stanley A. Schwartz, M.D., 2101 Medical Park Drive, #200, Silver Spring, MD 20902

D17368

May 20, 2008

|  |                        | For State Registrar  |  | of Marylan   | d / Depa                                    |                                   | t of H                            | ealth a             |                      | ental Hy                               | giene                    | 200                    | 8 171  | 7     |
|--|------------------------|--|--|--|---|-----------------------------------|-----------------------------------|---------------------|----------------------|--|--------------------------|------------------------|--|-------|
| Dhuaiaia   |                        | 1. Decedent's Name (First, Middle  | , Last)                                |  |   |                                   |                                   |                     |                      | 2. Date of De                          |                          | Year                   | 3. Time of Deat                              | th    |
| Physicia<br>/Medic   |                        | Johanna Grimes   |  |  |   |                                   |                                   |                     |                      | May 24                                 |                          | 08                     | 8:40 A                                       | М     |
| Examin   | er                     | 4a. Facility Name (If not institution  | -                                      |  |   | 4b. City,                         | Town, or                          | Location of         | of Death             |  | 1                        | County of Dea          |  |       |
|  | H                      | Montgomery Gene  5. Social Security Number   | ral Hosp:                              | ital<br>7. Age (In yrs.  | last hirthday)                              | 01ne                              |                                   | If Under            | 24 Hre               | 9 Date of Bir                          | Mor                      | ntgome                 | ry<br>rthplace <i>(Stat</i> e o <i>r For</i> | mian  |
| Funeral<br>Director  |                        | 055-09-7548  | 1 □ M 2 🗓 F                            | 7. Age (III yis.   |   | Months                            | Days                              | Hours               | Min.                 | 8. Date of Bir<br>(Month, Da<br>Aug. 4 | y, Year)<br>191          | 7 N                    | ountry) We York                              | eigii |
|  |                        | Usual Residence of Decedent  |  | ,  |   |                                   |                                   | 1                   |                      | 1105                                   | , ->-                    |                        | - TOTA                                       |       |
| rrylan<br>show   | _                      | 10a. State 10b. County   |  | 10c. Cit   | ty, Town or Lo                              | cation                            |                                   |                     |                      |  |                          |                        | 10d. Inside City Lin                         |       |
| e Ma<br>8a-f s   | cto                    |  | omery                                  | Bri  | inklow                                      |                                   |                                   |                     |                      |  |                          |                        | 1 □Yes 2 🔯                                   | No    |
| th with the Marylan<br>23a or 28a-f show<br>ust be rollifed at   | 盲                      | 10e. Street and Number   | 1. J                                   |  |   | 10f. Zip                          |                                   |                     |                      |  |                          | en of What C           |  |       |
| sath v   | eral                   | 20225 New Hamps  |  |  | 6 12  |                                   | 0862                              | ionanio Ori         | igin? /Cno           |  |                          | ed Sta                 | tes<br>erican Indian,                        |       |
| be filed within 72 hours after death with the Maryland ital Hygiene. dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at   | by Funeral Director    | 11. Marital Status  1 □ Never Married 2 □ Marri 3 ☒ Widowed 4 □ Divorced   | Armed For If Yes, G                    | ive  |   | fYes, spec<br>I∏Yes 2             | **                                | n, Mexican Specify: |                      | cify Yes or No<br>Rican, etc.)         |                          | Black, Whi             |  |       |
| 2 hou  | fed                    | 15. Decedent   | 's Education                           | atoo.  | 16a. Dece                                   | dent's Usua                       | al Occupa                         | ation               |                      |  | 16b. Kin                 | d of Busines:          | s/Industry                                   |       |
| permit. Pages 1 and 2 should be filed within 72 h<br>Department of Health and Mental hygiene.<br>Important: If item 27 is marked other than "natu<br>any Injury or other traumatic event, I'm Medical<br>once.   | Be Completed by        | (Specify only highes<br>Elementary/Secondary (0-12)  | college (                              | 1-4or 5+)  | Antid                                       | kind of wor<br>DO NOT us<br>Ue Me | k done d<br>se retired<br>C 1 C 2 | luring most         | t of workin<br>ok Sh | ng<br>NOP                              | Owr                      | ner                    |  |       |
| al Hyg<br>othe   | ge C                   | 17. Father's Name (First, Middle,  | Last)                                  |  |   |                                   |                                   | 18. Mothe           | er's Name            | (First, Middle                         | , Maiden S               | Surname)               |  |       |
| uld by<br>Menta<br>arked   | 9                      | Morris Rosenblu  | m                                      |  |   |                                   |                                   | Emma                | a Sil                | verman                                 | L                        |                        |  |       |
| 2 sho<br>and<br>is ma  |                        | 19a. Informant's Name/Relationsl   |  |  | 19b. Mailir                                 | ng Address                        | (Street a                         | and Numbe           | er or Rura           | l Route Numb                           | er, City or              | Town, State,           | Zip Code)                                    |       |
| and<br>tealth<br>m 27<br>her tr  |                        | Nancy Sherwood/  | Executrix                              |  | 4205  | Geldi                             | ng I                              | ane,                | 01ne                 | y, MD                                  |                          |                        | T 0: :                                       |       |
| ges 1<br>It of F<br>If ite<br>or ot  |                        | 20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation  | 3 🗆 Removal from                       | State Mon  | Place of Dispo<br>cemetery, crer<br>ntgomes | sition (Nan<br>natory or ol       | ne of<br>ther plac                | e) :                | May                  | 28,                                    |                          | -                      | r Town, State                                |       |
| t. Pa<br>rtmer<br>rtant;<br>rjury  |                        | 4 □ Donation 5 □ Other (Sp   |  | Cr   | ematori                                     | Lum, 1                            | Lnc.                              | i                   | 2000                 | ·                                      |                          |                        | Maryland                                     |       |
| Depa<br>Impo<br>any I  |                        | 21. Signature of Funeral Service   | Licensee                               | MO1  | 346 B                                       | ethes<br>ethes                    | da-C                              | hevy<br>MD 20       | Chas<br>0814         | e, Inc                                 | 755                      | 7 Wis                  | uneral Hom<br>consin Ave                     | •     |
| Physician  |                        | 23a. Part 1. Enter the disease, or<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | only one cause on<br>a.                | EPSIS  |   | er the mod                        | e of dyin                         | g, such as          | cardiac o            | r respiratory a                        | arrest,                  |                        | Approximate Interval Between Onset and Death | 1     |
| /Medical<br>Examiner   |                        | ,  | 20                                     | (or as a conseq  |   |                                   |                                   | 001                 | . 77                 |  |                          |                        | Musi   |       |
|  | ē                      | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury   |  | OSTREID  |   | IDCI                              |                                   | C 0C                | 1 113                |  |                          |                        | TAPI   |       |
| uted<br>d<br>ansit   | trial initiated events |  |  |  |   |                                   |                                   |                     |                      |  |                          |                        |  |       |
| be executed<br>ician and<br>burial-transit   |                        | resulting in death) Last   | Due to                                 | (or as a conseq  | uence of):                                  |                                   |                                   |                     |                      |  |                          |                        |  |       |
| ate be<br>nysici   | ical                   |  | d                                      |  |   |                                   |                                   |                     |                      |  |                          |                        |  |       |
| ertifica<br>ing pl   | Med                    | IF FEMALE:   |  |  |   |                                   |                                   |                     |                      |  | -1                       |                        |  |       |
| Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and rail director, page 2 should be detached for use as the burial-transit  | ysician/Med            | 23b. Was decedent pregnant in the past 12 moords? 1  Yes 2  No 9  Unknown  | 1 Live                                 | tcome of pregnation to the property of the pro | al death 3                                  | Ectopic pa<br>Other (sp           |                                   | /                   |                      |  | 2:                       | 3d. Date of d<br>Month | elivery<br>Day Year                          |       |
| that the   | y Phys                 | Part II. Other significant condition   | ns contributing to                     | eath but not res   | ulting in the u                             | nderlying ca                      | ause give                         | en in Part I.       |                      | 23e. Did                               | tobacco us               | se contribute          | to the cause of death                        | ?     |
| w requires t<br>been signe<br>should be o  | d by                   | ACUTE REN  | AL FAIL                                | re_  |   |                                   |                                   |                     |                      | 10                                     | Yes 2                    | 7No 3□                 | Probably 4 🗌 Unkn                            | own   |
| he law re<br>e has bee<br>tge 2 shoi   | Completed              |  |  |  |   | ·                                 |                                   |                     |                      | 24a. Was<br>auto<br>perfo              | psy<br>ormed?            | prior to<br>death?     |  |       |
| sician; The la<br>certificate ha<br>irector, page 2  | 0                      | 25. Was case referred to medical   |  |  |   |                                   |                                   | 26 Place            | of Death             | 1 ☐ Yes<br>(Check only o               | 2 🖃 No                   | 1 ∐Y€                  | s 2 No                                       | _     |
| ysician<br>iis certifii<br>director,   | 0                      | examiner?<br>1  Yes 2  No  | Hospital: 1                            | Inpatient 2  | ER/Outpatier                                | nt 3 🗆 D0                         | Othe                              | ar.                 |                      | ne 5 ☐ Resi                            |                          | □Other (St             | pecify)                                      |       |
| ng Ph<br>ter th  | Certification: To      | 27. Manner of Death  | 28a. Date                              | of Injury<br>oth, Day, Year)   | 28b. Time o                                 | 2                                 | 8c. Injun                         | y at                |                      | 28d. Describe                          |                          |                        |  |       |
| Attending<br>ir dea h.<br>ector After<br>by the funer  | atic                   | 1 Natural 5 Pending 2 Accident investig  | ation                                  | , = ω,,  | ,,  | М                                 |                                   | Yes 2□              | No                   |  |                          |                        |  |       |
| or Att<br>ter de<br>irect<br>n by t  | ij                     | 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ   | ined   28e. Plac                       | e of Injury - At h<br>ling, etc. (Speci  |   | eet, factory                      | , office                          |                     | 2                    | 28f. Location (<br>City or To          | Street and<br>wn, State) | Number or i            | Rural Route Number,                          |       |
| To the Hospital or Attending Phys within 24 hours after dea h. To the Funeral Director After this completely filled in by the funeral director and |                        | 29a. Certifier 1 ☐ Certifyin (Check only 2 ☐ Medical   | g Physician: To th<br>Examiner: On the | e best of my kno   | owledge, deat                               | h occurred                        | at the tir                        | ne, date ar         | nd place, a          | and due to the                         | cause(s)                 | and manner             | as stated.                                   |       |
| the hin 2, the F   | Medical                | one)   | and mai                                | ner stated.  |   |                                   |                                   |                     |                      |  |                          |                        |  |       |
| <b>5</b> ≥ 0 0 0   | =                      | 29b. Signature and title of certifier  |  | -  |   |                                   |                                   | e number<br>GSC     | 61                   |  |                          | Signed (Moi            | nth, Day, Year)<br>X○♥                       |       |
|  | 1                      | 100  |  |  | 00.1  |                                   | , 00                              | 456                 |                      |  | 7/0                      | 77100                  | 6  |       |
| 10   |                        | 30. Name and address of person Debovch Stew  | . 0.                                   | se of death (Iter  | n 23a) (Type,<br>JCL Ph                     | erint)                            | Rive                              | 010                 | very,                | MD 2                                   | 0833                     | >                      |  |       |
| Stat   | e                      | 31. Date filed (Month, Day, Year)  | 32. 1                                  | Registrar's Signa  | ature                                       |                                   |                                   |                     | 1.                   | <del></del>                            |                          |                        |  |       |
| Registra   |                        | MAY 2  | 8 2008                                 | Elizare.   | K A   | best                              | 0                                 |                     |                      |  |                          |                        |  |       |
|  |                        |  | -                                      |  | 6 4   |                                   |                                   |                     |                      |  |                          |                        |  |       |

DHMH 17 Rev 1/2001

# Pages 1 and 2 should be filed within 72 hours after death with Baltimore, Maryland 21215-0036

**Funeral** 

Director

28a-f show

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"natural"

of Health and Mental Hygiene. I item 27 is marked other than

Department of Heal Important: If item 2 any Injury or other once.

**Physician** 

/Medical

**Examiner** or Attending Physician: The law requires that the death certificate be executed and attending physician for use as the burial Box 68760. O. à been signed b should be deta Division of Vital Records. has e 2 s certificate within 24 hours arter co...

To the Funeral Director: Af

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Reg. No. 2008 State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY **Physician**  $23^{y}$ 2008 12:00 P M GOSTOMSKI JUSTINA MARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A 335 GUSRYAN ST. BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day You JUNE 30, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign , 1938 PENNSYLVANIA Days 1 □ M 2 ₩ F Months Hours Min. 69 220-36-6348 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State MaryYes 2 □ No Director BALTIMORE N/A MD. 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code UNITED STATES 335 GUSRYAN ST. 21224 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No Specify: ð Specify: WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4or 5+) ARRANGER FLORIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANASTASIA SUCHODOLSKI MICHAEL YAKIM ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 335 GUSRYAN ST., BALTIMORE, MARYLAND 21224 LEONARD T. GOSTOMSKI/HUSBAND 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) W Burial 2 ☐ Cremation 3 ☐ Removal from State ST. STANISLAUS 5/27/2008 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Funeral Service Licens 6224 EASTERN AVE., BALTIMORE, MARYLAND 21224 23a. Part 1. Enter the disease, or conshock, or heart failure. List only prefications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OVARIAN CANCER disease or condition -resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Year Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 □Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed HYPERTENSIO 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 D Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State 'Registrar ASM

31. Date filed (Month, Day, Year) MAY 2 8 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4920

32. Registrar's Signature

D0061480

CAMPBELL BLVD WHITE MARSA MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 05 26 2008 11:00p.M Mohamed Ahmed Elseayed Mohamed Hassan 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Nursing Home If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09 29 58 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1 XM 2 ☐ F 49 217-55--1126 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Perry Hall MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 15003 Dorthy Field Road U.S.A. 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2√☐ No Specify: Egyption 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Lawyer 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ahmed Elseayed Mohamed Hassan Fathia Abou-Hgar 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 19a. Informant's Name/Relationship (Type. Print) 15003 Dorthy Field Road, Perry Hall, Md Tarek Ahmed-Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 5/27/08 Woodlawn, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. 21215 4300 Wabash Ave, Baltimore, Md Approximate Interval Between Onset and Death diate Cause (Final disease or condition resulting in death) HEPATOCELLULAR CAREINOMA, METESTATIC MONTHS Due to (or as a consequence of): HEPATITIS Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ✓ Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an

/Medical

Department of Health a Important: If Item 27 is any injury or other trainonce.

Physician

**Examiner** 

**Funeral** 

**Director** 

ortant; if Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Modical Examinar must be nothed at

12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "r

Pages 1 and 2 should be nent of Health and Mental

Maryland

Baltimore,

with the Maryland

/Medical

Director

Funeral

Be Completed

**Physician** Examiner

that the death certificate be o Vital Division Hospital or Attending after death Director: filled in by e Funeral I within 2.

E

Physician/Medical 23b. Was decedent pregnant in the past 12 months? 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. þ Be Completed autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year) D64395 MAY 26, 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

6565 N CHARLES ST: SUITE 209 BALTIMORE, NO ZIZO DANIEUE OUBERMAN, MO 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar





amend #6 Per State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 05 2008 12:05pM Simmons Hawkins Mary Amanda /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Manor Care Nursing Home If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 524-30-4172 **Director** 84 10 26 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be prefitted at any Injury or other traumatic event, the Medical Examiner must be prefitted at once. 10a. State X□Yes 2□No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21223 2402 West Lexington Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No tf Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Black 2 3√ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm. 12th grade Claims Examiner 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Simmons Mary A. Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4819 Manor Lane, Ellicott City, Md 21042 Yovonda Brooks-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 6/2/08 Owings Mills, Md 22. Name and Address of Facility
March F/H West 21 Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Par M. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): physician Box 68760. the attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 □Yes 2 Mo Ö been signed by the should be detached 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ ERTENSIVE CARDIOVASCULAR Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b autopsy performed 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Suursing Home 5 Residence 6 Other (Specify) this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00059107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Business 210 Ima 32. Represtrar's Signature 31. Date filed (Month, Day, Year) State 8 2008 Registrar

DHMH 17 Rev 1/2001

# permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland 05|24|08 TOD 0453am Baltimore, Maryland 21215-0036 Hinkle, Clyde M800484383 Division or Vital Records, P.O. Box 68760, So to the Hospital or Attending Physician: The law requires that the death certificate be executed

|   |  | State<br>Registrar   | (=)  |                                    |  |  |   | Certi  | ficate of  | Health and Death   | _  |  | 3  | 00   |  | 2 Tim=   |
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| BeC   | 17. F  | Father's Name  | (First, Middle,  | Last)                              | •  |  |   |  |  | 18. Mother's Na  | ame (Fir   | rst, Middle, M   | laiden Suri  | name)  |  |  |
| To B  |  | Harry 3  | J. Hink  | :le                                |  |  |   |  |  | Lula (   | (unk)  | ) Mill   | er   |  |  |  |
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|   | 21.  | Signature of Fu  | uneral Service   | Liconseo                           |  |  |   | 22. N  | Name and Addre   | ess of Facility<br>uneral H  | Tome   | . Р Д  |  |  |  |  |
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8606 220 DM **Physician** Mai Leona May Hughes /Medical 4c. County of Death HARFOR 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KWERSIDE EIC AM If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🔀 F 86 West Virginia Director 234-26-4721 May 8, 1922 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21085 308 Stillmeadow Drive USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: 3X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Assistant Oil Refining 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jasper Oliver Bleigh Lura Bell Prunty ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Harrison / POA 306 Stillmeadow Dr., Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 Removal from State Meadowridge Mem. Pk. 5-28-08 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa (Te Funeral Service Licens 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or compli-shock, or heart failure. List only ontions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, le case on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myscardial /Medical Due to (or as a lonsequence of): Examiner Emphysema Sequentially list conditions, if any, leading to thim ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a pursi Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? res 2 No Hospital or Attending Physician: Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 🔲 Inpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral L 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) completely and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) MAY 2 8

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Month Mod

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2008 A Ann /Medical Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 🗶 F Months Davs Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Show If Item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 120 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bace - American Indian. 11. Marital Status Black, White, etc 1 Tes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedents usual Occupation
(Give kind of work one during most of working
life. DO NOT use retired)

UTSUAOMiniStrator Hygiene, other than " College (1-4or 5+) Elementary/Secondary (0-12) and Mental Hygin Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be f 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 6 Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 **→** ₩ Burial 2 ☐ Cremation 3 Removal from State Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) re of Funeral Service Licensee lto Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. ng, such as cardiac or respiratory arrest, Immediate Cause (Final smell cell LUN **Physician** Non Concer disease or condition resulting in death) Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed Due to (or as a consequence of) attending physician if for use as the burial-68760, Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the 9 Unknown 9 Unknown ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ທົ The law requires Record 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has autopsy certificate 1 □Yes 2 No Vital funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 Tes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) UBSPICE Certification: To 5 Residence this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours. 29a. Certitier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29b. Signature and title ot certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WES 31. Date filed (Month, Day, Year) \$2. Registrar's Signature MAY 2 8 2008 Registrar

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State Registrar

DHMH 17 Rev 1/2001

Vinu Ganti, M.D.

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31. Date filed (Month, Day, Year)

32 Registrar's Signature

Germantown, Maryland 20874

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 23<sup>Day</sup> 2008 Month MAY **Physician** HARRIS 10:30A M HERBERT /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BALTIMORE PIKESVILLE NORTH OAKS HEALTH CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 04/21/1907 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country Hours Months Days 101 218-18-9653 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Mactical Examine 1. As the neutrical anonce. 1 Yes 2 No Director PIKESVILLE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 725 MT. WILSON LANE, #439 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ATTORNEY LAW 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BLOCK HARRIS TILLYE **JACOB** ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 725 MT. WILSON LANE, #439, PIKESVILLE, MD 21208 SARAH HARRIS / WIFE Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemeters cranaters or other place)
MEMORIAE PARK 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 05/25/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. brott 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Preumonia /Medical Due to (or as a consequence of): **Examiner** Dysphagia Sequentially list conditions, if any leading to in reduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Luc it (or as a non-anguence of) Hospital or Attending Physician: The law requires that the death certificate be executed Dementia and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, aftending physician for use as the buria Physician/Medical If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Failure Gronary artery 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Prostate concer Infiltrating Carcinoma of 24a. Was an performed' the suin (ON the Back) 1 ☐ Yes 2 XNo within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, it 25. Was case referred to medical examiner?
1 ☐ Yes 2 ▼No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Maren L. Balitt, M.D. 1200 58676 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , 4000 old court Road suite 301, Faithmore, MD 21208 Maren L. Babitt, Mir.

State Registrar 31. Date filed (Month, Day, Year) MAY 2 8 2008

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Reg. No 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** GERTRUI 3 08 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PARKVILLE BALTIMORE OAKCREST If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/24/1919 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Hours Days Months 1 □ M 2 📉 GERMANY 216-32-2067 88 Vrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2□No Director MD. BALTIMORE PARKVILLE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8822 WALTHER BLVD. **ROOM 225** Funeral 21234 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Year or Dates: WHITE 1 ☐ Yes 2 No Specify Completed by 3 ₩idowed 4 Divorced 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) INSURANCE ADJUSTER INSURANCE 12TH 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be AUGUST FRIEDRICH MARIE UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33036 19a. Informant's Name/Relationship (Type. Print) NELSON HALLMAN/SON 88005 OVERSEAS HWY., SUITE 9616 ISLAMORADA, FL. Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Purial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) OAK LAWN CEMETERY 5/27/2008 BALTIMORE, MARYLAND 22. Name and Address of Facility 21. Signature of Funeral Service Licensee CHARLES S. ZEILER & SON, INC. 6224 EASTERN AVE., BALTIMORE, MARYLAND sase or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1 El ter the di Immediate Cause (Final disease or condition resulting in death) DICHMONIA **Physician** /Medical Due to (or as a con a guence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 1 No Division or Vital To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0 12

State Registrar

31. Date filed (Month, Day, Year)

Ducca

32. Registrar's Signatu 7 2008

30. Name and address of person who completed cause of death (Item 2)

Diumen Those

Sop Sop

Certificate of Death

DHMH 17 Rev 1/2001

0

State

Registrar

For State Registrar

2866

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

501

32. Registrar's Signature,

Naresh Punjabi

8 2008

31. Date filed (Month, Day, Year)

D46132

South Union St, Havre de Grace, MD 21078

|             |   | 4                 | Amend #5,11,perl   | State of Mar<br>Nf, G88 6/5/                            | yland<br>08 TT | Department Certificate                               |  | d Mental          | Hygier<br>Reg. N                  | e 2008                           | 17190  |
|-------------|---|-------------------|--|---|----------------|--|--|-------------------|-----------------------------------|----------------------------------|--|
|             |   |                   | Registrar  1. Decedent's Name (First, Middle, Last)                                |   |                |  |  | 2. Date           | of Death                          |                                  | 3. Time of Death                                 |
|             | Physicia  | an                |  |   | AT. M          |  |  | Mont              |                                   | ay Year 2008                     | 10:08 PM   |
|             | /Medic  |                   | JAMES LANKFORD  4a. Facility Name (If not institution, give                        | street and number)                                      |                | 4b. City. To   | wn, or Location of D                           |                   | /                                 | lc. County of Death              |  |
|             | Examin  | er                | Sinai Hospito  | D of Ba   | Shim           | Ide Bay  | timole   | Cit               | 4                                 |                                  |  |
|             | Funeral   |                   | 5. Social Security Number / 6. Sex   | 7. Age (  | In yrs. last   | birthday) If Under 1                                 |  | Hrs. 8. Date      | of Birth<br>th, Day, Yea          | 9. Birthp                        | ace (State or Foreign                            |
|             | Director  |                   | 214-49-4874 1X   | M 2□F   | 62             | Yrs. Months E  | Days Hours I                                   | 06/0              | 2/19                              | 45 BALTI                         | MORE, MD   |
| 4           | 9   |                   | Usual Residence of Decedent  |   | 0 0't 7        |  |  |                   |                                   | 11                               | Od. Inside City Limits                           |
|             | show  | _                 | 10a. State 10b. County   | ,   | uc. City, I    | own or Location                                      |  |                   |                                   |                                  | 1X Yes 2 No                                      |
| -           | Ba-f s  | cto               | MD   |   | BAL            | TIMORE   |  |                   | 10                                | Citizen of What Coun             |  |
| 1           | 9 or 1  | Dire              | 10e, Street and Number   |   |                | 10f. Zip C   |  |                   | 10g.                              | USA                              | ay:  |
| -           | tiled within 72 hours after death with the Maryland Hygiene. Hygiene Han "natural", or items 23a or 28a-f show ent, true Mardical Exaction on our bar notified.   | Funeral Director  | 4909 BELLE AVE   |   |                |  | 207<br>nt of Hispanic Origin                   | 2 /Specify Vos    | or No-                            | 14. Race - Americ                | an Indian  |
| -           | items   | un                | **   | 12. Was Decedent Eve<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No | er in U.S.     | If Yes, specify                                      | Cuban, Mexican, F                              | Puerto Rican, et  | c.)                               | Black, White,                    |  |
| 0 .         | , or  | by F              | ¥ Never Married 2 Married 3 Widowed 4 M Divorced                                   | If Yes, Give<br>Year or Dates:                          |                | 1 □Yes 2   | No Specify:                                    |                   |                                   | Specify: BL                      | ACK  |
| 3.          | tural   |                   | 15. Decedent's Edu   |   | - 1            | <br>  6a. Decedent's Usual (                         | Occupation                                     |                   | 16b                               | Kind of Business/Inc             | iustry   |
| 2           | n /2<br>n "na<br>ladio  | Completed         | (Specify only highest grad   | e completed)  |                | (Give kind of work<br>life. DO NOT use               | done during most of<br>retired)                | f working         |                                   |                                  |  |
| <u> </u>    | with<br>jiene.  | E                 | Elementary/Secondary (0-12)  | College (1-4or 5+)                                      |                | SEAFOOD (  | CLERK  |                   | - 0                               | ROCERY                           |  |
| 0           | Hyg<br>other<br>ent,  | Be C              | 17. Father's Name (First, Middle, Last)  |   |                |  | 18. Mother's                                   | Name (First, A    | Middle, Maio                      | len Surname)                     |  |
| <u>a</u>    | ld be<br>lenta<br>ked<br>ked  | To B              | JAMES L. JACKSO  | N SR  |                |  | SALI   | LIE GA            | RLANI                             | )                                |  |
| عر          | shour and N mail  |                   | 19a. Informant's Name/Relationship (T)   |   |                | 19b. Mailing Address (5                              | Street and Number                              | or Rural Route    | Number, Cit                       |                                  |  |
| Ž           | alth alth 2 27   27   3r tra  |                   | ALIKIA JACKSON-  | - DAUGHTE   | R              | 3912 WYA   | TT DRIVE                                       | E, GWY            | NN O                              | AK, MD                           | 21207  |
| <b>a</b>    | item<br>item<br>othe  |                   | 20a. Method of Disposition   |   |                | e of Disposition (Name<br>netery, crematory or other | of<br>er place)                                | Date              |                                   | Location - City or To            |  |
| E .         | Page<br>nent c<br>nt: If<br>ry or   |                   | 1 A Burial 2 □ Cremation 3 □ F<br>4 □ Donation 5 □ Other (Specify)                 | lemoval from State                                      | DRUI           |  |  | 5/31/0            | 8 P1                              | KESVILL                          | E, MD  |
| altimo      | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylah Department of Health and Mental Hygiene. Because the mass 29a or 28a-f show important: If them 27 is marked other than "natural", or items 20a or 28a-f show any Injury or other traumatic event, the Marical Examination in other traumatic event, the Marical Examination in other traumatic event, the Marical Examination in other profiles. |                   | 21. Signatur uneral Servic   | ee  | 1              |  |  |                   |                                   | ERAL HON                         |  |
| Ď           | B B E B   |                   | Mund 4   | mull &  | K.             | 4600 I   | LIBERTY  | HEIGHT            | rs AV                             | E, BALTI                         | MORE, MD   |
|             |   |                   | 23a. Part 1. Enter the disease, or compl<br>shock, or heart failure. List only o   | ications that caused the                                | ne death.      | Do not enter the mode                                | of dying, such as ca                           | ardiac or respira | tory arrest,                      |                                  | Approximate<br>Interval Between                  |
| , F         | hysician  |                   | Immediate Cause (Final disease or condition  | ie cause on caon inc                                    | · Les          | static 1   | Pancreo  | abir.             | coun(                             | er.                              | Onset and Death                                  |
| The same    | /Medical  |                   | resulting in death)  | a. Due to (or as a                                      | consequer      |  | 0.10.0   | 0 / 0             |                                   |                                  | ,  |
| -           | Examiner  |                   |  | h   |                |  |  |                   |                                   |                                  |  |
|             |   | ner               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying | Due to (or as a   | conseque       | nce of):   |  |                   |                                   |                                  |  |
|             | executed and and all-transit  | Examiner          | that initiated events  | c   |                |  |  |                   |                                   |                                  |  |
| g,          | e exe<br>ian a<br>ırial-t   |                   | resulting in death) Last   | Due to (or as a   | conseque       | nce of):   |  |                   |                                   |                                  |  |
| ~           | cate be executed only sician and the burial-transit   | dical             | •  | d   |                |  |  |                   |                                   |                                  |  |
| ا ق         | certifica<br>nding plase as t   |                   | IF FEMALE:   |   |                |  |  |                   |                                   |                                  |  |
| NOX<br>POX  | ath ce<br>ttend<br>or use   | an/               | 23b. Was decedent pregnant in the past 12 months?                                  | 23c. If yes, outcome of<br>1 ☐ Live birth 2             | ☐ Fetal d      | eath 3 Ectopic pre                                   |  |                   |                                   | 23d. Date of deliver Month       | ery<br>Day Year                                  |
| 5           | e dez<br>the a<br>red fo  | Sici              | 1 Yes 2 No   | 4 ☐ Pregnant at t<br>9 ☐ Unknown                        | ime of dea     | th 5 ☐ Other (spe                                    | cify)  |                   |                                   |                                  |  |
| 7.          | nat th<br>d by<br>etach   | Physician/Me      | Part II. Other significant conditions co   | intributing to death but                                | not resulti    | ng in the underlying car                             | ise given in Part I.                           | 236               | e. Did tobac                      | co use contribute to             | he cause of death?                               |
| Š,          | res the signe pe d  | þ                 |  |   |                | ng in are areary ng said                             | <b>3</b> • • • • • • • • • • • • • • • • • • • |                   | 1 □ Yes                           | 2 □ No 3 □ Pro                   | bably 4 Unknown                                  |
| 0           | law requires that the death certific<br>as been signed by the attending p<br>2 should be detached for use as t  | ted               | Hypercor   | tisolier  |                |  |  | _                 |                                   |                                  |  |
| ec          | law<br>nasb<br>e 2 sk   | l ple             | Hyper  | ansi an   |                |  |  | 248               | a. Was an<br>autopsy<br>performed | prior to co                      | opsy findings available<br>empletion of cause of |
|             | sician: The lav<br>certificate has<br>rector, page 2:   | Completed         |  |   |                |  |  |                   | Yes 2                             | No 1 ☐ Yes                       | 2 12 No  |
| 113         | Attending Physician: It death. ector: After this certific. by the funeral director, I   | Be                | 25. Was case referred to medical examiner?   | (Increite)  |                |  | Othori   | of Death (Check   |                                   |                                  |  |
|             | hysl<br>this c  | 은                 | TE Yes ZEINO   |   |                | R/Outpatient 3 DOA  8b. Time of 28                   |  |                   |                                   | e 6 ☐ Other (Specinjury occurred | ify)   |
| בַ          | ing f   | ino.              | 27. Manner of Death 1 ☑ Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day,                     |                | Injury M   | c. Injury at<br>Work?<br>1 □ Yes 2 □ No        |                   | scribe now                        | rijury occurred                  |  |
| Sic         | tend<br>leath<br>tor: /<br>the f  | cat               | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be                            | One Blace of Inity                                      | At hom         |  |  |                   | ation /Stree                      | t and Number or Ru               | al Route Number.                                 |
| Division of | or At<br>fter c<br>direction by   | Certification: To | 4 Homicide determined  | building, etc.  | (Specify)      | e, farm, street, factory,                            | onice  | City              | or Town, S                        | State)                           | ar riodio rombon                                 |
| _           | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,   |                   | 29a. Certifier 1 Certifying Phy  | vsician: To the best o                                  | f my know      | ledge, death occurred a                              | t the time, date and                           | place, and due    | to the cau                        | se(s) and manner as              | stated.  |
|             | Hos<br>24 ho<br>Fun<br>Fun  | Medical           | (Check only 2 Medical Exam   | iner: On the basis of<br>and manner stat                | examinatio     | on and/or investigation,                             | in my opinion, death                           | h occurred at th  | e time, date                      | and place, and due               | to the cause(s)                                  |
|             | ithin ithin on the omple  | Mec               | 29b. Signature and title of certifier  | and marrier state                                       | -              | 29c.   | License number                                 |                   | 29d                               | Date signed (Month               | , Day, Year)                                     |
|             | F ≯F ŏ  |                   | Harithe Per  | dle   |                | i  | 065718   | 3                 | 1                                 | 10y 23,                          | 2008   |
|             | 2 Í   |                   | 30. Name and address of person who d   |   | ath (Item 1    | 23a) (Type Print)                                    |  |                   |                                   | , 7                              | MODE   |
|             | 11  |                   | · ·  | JDLI /  | MD             | SINAJ  | HOSPI  | LTAL              | Of                                | BALTI                            | MURC   |
|             | Sta   | ate               | 31. Date filed (Month, Day, Year)  | 32, Registra  | r's Signatu    | re   |  |                   |                                   |                                  |  |
|             | Regist  |                   | MAY 0 0 200  | 0   | 10             | frank o  |  |                   |                                   | *                                |  |

DHMH 17 Rev 1/2001

James

known ag

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per ft 8879 5-28-08 yt.
State of Maryland Pepartment of Health and Mental Hygiene 2008

|  | 1                | state of Maryland A  | Certificate of De  | eath  | Reg. N                     | lo.                           |  |
|--|------------------|--|--|---|----------------------------|-------------------------------|--|
|  |                  | 1. Decedent's Name (First, Middle, Last)   |  | 2.  | Date of Death<br>Month     | ay Year                       | 3. Time of Death                                   |
| rsicia:<br>ledica  |                  | Karen Ann Jackson  |  | N   | lay 20,                    | 2008                          | 12:15 A.   |
| amine  | er '             | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Loc                                   | cation of Death                             | I .                        | lc. County of Dea             |  |
|  |                  | Greater Baltimore Medical Center   | TOWS   |   | Date of Birth              | altimore                      | thplace (State or Forei                            |
| eral   | 1                | 5. Social Security Number 6. Sex 1 □ M 2 ☒ F  5. Age (In yrs. last bir   |  | lours Min.                                  | (Month, Day, Yea           | (r) $(c)$                     | falo, N.Y.   |
| tor  | -                | 078-42-6649  |  | F   | PLTI 221                   | 1991 Dui                      | .1410/11.1.  |
| <b>=</b>   | -                | 10a. State 10b. County 10c. City, Tow  | n or Location  |   |                            |                               | 10d. Inside City Limi                              |
|  | 호                | Maryland Baltimore County Tinc   | nium   |   |                            |                               | 1 □ Yes 2 🔼 I                                      |
| TOL .  | <u>.e</u>        | 10e. Street and Number   | 10f. Zip Code  |   | "                          | Citizen of What Co            |  |
| st De  | Funeral Director | 15 Salthill Court  | 210  | 093   | Ur                         | nited Sta                     | ites   |
| Ē  | Iner             | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | 13. Was Decedent of Hispa<br>If Yes, specify Cuban, N    | anic Origin? (Specif<br>Mexican, Puerto Ric | y Yes or No-<br>can, etc.) | 14. Race - Ame<br>Black, Whit |  |
| u l  | <b>元</b>         | 1 ☑Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No<br>If Yes, Give  | 1 ☐ Yes 2 ☒ No S   | Specify:                                    |                            | Specify: Afr                  | rican Amer   |
| Exa  | g p              | 3 ☐ Widowed 4 ☐ Divorced Year or Dates:  | Decedent's Usual Occupation                              | .n  | 16h                        | Kind of Business              |  |
| dica   | Completed        | (Specify only highest grade completed)   | (Give kind of work done during life. DO NOT use retired) | ng most of working                          | 100                        | Tring of Duariesa             | , madatiy  |
| e M  | Ĕ                | Elementary/Secondary (0-12) College (1-4or 5+)   | lministrative .  |   | l                          | ollege Ad                     | dministrat   |
| ent, <u>t</u>  |                  | 17. Father's Name (First, Middle, Last)  |  | I. Mother's Name (/                         |                            | len Surname)                  |  |
| S C  | To Be            | Everett Leonard Jackson  | D  | aisy Mae                                    | Smith                      |                               |  |
| or other traumatic event, the Medical Examiner must be notified at | ┺┟               | 19a. Informant's Name/Relationship (Type. Print) 198   | . Mailing Address (Street and                            |   |                            |                               |  |
| ir tra   |                  | Karol Ann Shropshire (Sister) 62   | 28 Norfolk Ave   | . Buffa                                     | alo, New                   | York .                        | 14215<br>  |
| et e   |                  | cometa   | f Disposition (Name of<br>ry, crematory or other place)  | Dat   |                            | Location - City or            | r Town, State                                      |
| <u>7</u>   |                  | 1 ☐ Burial 2 🖺 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evans   | Funeral Chape  | - / / / / / /                               | FO]                        |                               | l, Marylan   |
| any Injury or once.  | ı                | 21. Signatura Juneral Service Licensee   | 22. Name and Address of Peaceful Alt                     | of Facility                                 | s Funera                   | l&Cremat:                     | ion Ctr.,F   |
| a G  | - 1              | Then of your in  | '  2325 Vork R   | ?oad Tii                                    | monium.Ma                  | aryland                       | 21093  |
|  |                  | 23a. Part J. Enter the disease, or complications that caused the death. Do shook, or heart failure. List only one cause on each line.          | not enter the mode of dying, s                           | such as cardiac or i                        | respiratory arrest,        |                               | Approximate<br>Interval Between<br>Onset and Death |
| ian  |                  | Immediate Caus (Fina disease or condition Breast Cancer  |  |   |                            |                               | 5 years  |
| ical   |                  | resulting in death)  Due to (or as a consequence   | of):   |   |                            |                               |  |
| ner  |                  | Sequentially list conditions. b.   |  |   |                            |                               |  |
| sit  | Examiner         | Sequentially list conditions, if any, leading to immediate cause (Disease or injury)  b. Due to (or as a consequence cause (Disease or injury) | 01):   |   |                            |                               |  |
| -tran  | хап              | that initiated events resulting in death) Last C. Due to (or as a consequence  | of):   |   |                            |                               |  |
| is the burial-transit  | コー 田             |  | ,  |   |                            |                               |  |
| s the  | dical            | d  |  |   |                            |                               |  |
| for use as   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy  |  |   |                            | 23d. Date of de               | elivery  |
| d for  | icia             | in the past 12-months?  1  | h 3 ∐Ectopic pregnancy<br>5 ☐ Other (specify)            |   |                            | Month                         | Day Year   |
| ache   | hys              | 9 ☐ Unknown  |  |   |                            |                               |  |
| e det  | by P             | Part ii. Other significant conditions contributing to death but not resulting  | in the underlying cause given i                          | in Part I.                                  |                            |                               | to the cause of death                              |
| should be detached   | edi              |  |  |   | 1 Yes                      | 2  No 3 F                     | Probably 4 🖺 Unkn                                  |
| 2 shc  | Completed        |  |  |   | 24a. Was an autopsy        | 24b. Were a                   | autopsy findings avail<br>completion of cause      |
| page   | m o              |  |  |   | performer                  | i? death?<br>No 1 ☐ Ye        | s 2 No   |
|  | Be               | 25. Was case referred to medical examiner?   | 20   | 6. Place of Death                           | Check only one)            |                               |  |
| al dire  | 10<br>10         | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/O  |  | 4   Nursing none                            |                            |                               | ecify)   |
| funera   |                  | 1 Naturai 5 □ Pending (Month, Day Year)  | Time of lnjury at Work?                                  |   | 3d. Describe how i         | njury occurred                |  |
| the f  | Certification:   | 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 280 Place of injury. At home to  |  | s 2 No                                      | of Location (Street        | t and Number or               | Rural Route Number,                                |
| in by  | Ħ                | 3 Suicide 4 Homicide  6 Could not be determined  28e. Place of injury - At home, to building, etc. (Specify)                                   | am, succi, iactory, office                               | 28  | City or Town, S            |                               | Terrai i Touto Transcor                            |
| lled   | ပိ               | 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge   | e, death occurred at the time                            | , date and place, at                        | nd due to the caus         | se(s) and manner              | as stated.   |
| -  | Medical          | (Check only one)  Medical Examiner: On the basis of examination a andmanner stated.  | nd/or investigation, in my opin                          | nion, death occurre                         | d at the time, date        | and place, and d              | ue to the cause(s)                                 |
| etely fi   | Mec              | 29b. Signature and title of certifier  | 29c. License n   | umber                                       |                            | Date signed (Mo.              |  |
| ompletely fi   |                  | ► NINVII 0/1/18/18/18/18/18  | D39099   |   | Ma                         | y 21, 20                      | 800  |
| completely filled in by the  |                  |  |  |   |                            |                               |  |
| completely fi  |                  | 30. Name and address of person und completed cause of death (Item 23a)   | (Type, Print)  |   |                            |                               |  |
| completely fi  |                  | 30. Name and address of person who completed cause of death (Item 23a) Rodney W. Williams, M.D. 6701 No.                                       | (Type, Print)<br>orth Charles Si                         | treet #3                                    | 3213 Tow                   | son,Mary                      | vland 212  |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lolury or other traumatic event, the Moderl Eventinar must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

**Physician** Examiner To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, Sta Registi DHMH 17 Rev 1/2001

|                                  | For<br>State<br>Registrar   | cei  | rtificate of l  |                                  |               | Re                            | g. No. 200                         | 8 17192  |
|----------------------------------|---|--|---|----------------------------------|---------------|-------------------------------|------------------------------------|--|
| n                                | 1. Decedent's Name (First, Middle, Last)  |  |   |                                  | 2.            | Date of Death<br>Month        |                                    | 3. Time of Death                                     |
| al                               |   | nomas  |   | nson                             |               | 05                            | 23 2008<br>4c. County of Dea       |  |
| er                               | 4a. Facility Name (If not institution, give street and number 5 Pleasant Ridge Dr,  | <sup>7</sup><br>∤507                               | 4b. City, Town, or Owing                                      |                                  |               |                               |                                    | imore  |
|                                  | 5. Social Security Number 6. Sex 7. A   | ge (In yrs. last birthday)                         | If Under 1 Year<br>Months Days                                |                                  |               | Date of Birth<br>(Month, Day, | Year) 9. Bi                        | rthplace (State or Foreign<br>country)               |
|                                  | 214-30-5689   | 74 Yrs.  | World Buy   | Tiodio                           | b8            |                               | 33                                 | MD   |
|                                  | 10a. State 10b. County  | 10c. City, Town or Lo                              | ocation   |                                  |               |                               |                                    | 10d. Inside City Limits                              |
| ctor                             | MD Baltimore  | Ov   | wings Mi  | lls                              |               |                               |                                    | 1 □Yes 2X□No   |
| Dire                             | 10e. Street and Number  | "507   | 10f. Zip Code   | 117                              |               | 10                            | og. Citizen of What C<br>U • S • A | -  |
| era                              | 5 Pleasant Ridge Dr.,   |  |   |                                  | gin? (Specifi | Yes or No-                    | 14. Race - Am                      |  |
| Εū                               | Armed Forces  | ] No [   | Was Decedent of H   |                                  | , Puerto Ric  | an, etc.)                     | Black, Wh                          | ite, etc.  |
| d by                             | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates   | .  | 1 □ Yes 2 No  | Specify:                         |               |                               |                                    | Black  |
| olete                            | 15. Decedent's Education<br>(Specify only highest grade completed)  | (Give  | dent's Usual Occup<br>kind of work done<br>DO NOT use retired | ation<br><i>luring mos</i><br>l) | t of working  | 1                             | 16b. Kind of Busines               | s/Industry   |
| mo;                              | Elementary/Secondary (0-12) College (1-4or 12th grade na  | (5+)   | inistrat  |                                  |               | •                             | IBM                                |  |
| Be Completed by Funeral Director | 17. Father's Name (First, Middle, Last)   |  |   |                                  |               |                               | laiden Surname)                    |  |
| မ                                | William Johnson   | 405 44-77  | A.I.I (Oh   |                                  | Robin         |                               | Oit as Taura Chata                 | Zin Ondah  |
|                                  | 19a. Informant's Name/Relationship (Type. Print)  Paula Hackett Johnson   | -Wife 5  | ng Address ( <i>Street</i><br>P <b>leasant</b>                | ana Numbe<br>Ric                 | ar or Hurai H | r . # f                       | 507. Owi                           | Zip Code)<br>MD 21117,<br>ngs M1113,                 |
|                                  | 20a. Method of Disposition  | 20b. Place of Dispo                                |   |                                  |               |                               | 20c. Location - City of            |  |
|                                  | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Contains 5 ☐ Other (Specify)  | Howard   | ,   | · .                              |               | 1                             | Washingt                           | on, DC   |
|                                  | 21 Signature of Funeral Service Licensee  | M. M.  | 2. Name and Addre<br>arch F/I<br>300 Waba                     | I Wes                            | št            | Dalein                        | more, Md                           | 21215  |
|                                  | 23a. Part 1 Enter the disease, or complications that cluss show, or heart failure. List only one cause on each                  |  |   |                                  |               |                               |                                    | Approximate<br>Interval Between                      |
|                                  | Immediate Cause (Final liseare or condition a   | Acute n  |   |                                  |               |                               |                                    | Onset and Death                                      |
|                                  | Due to (or a  | s a consequence of):                               |   |                                  |               |                               |                                    | Manut  |
| ē                                | Sequentially list conditions,   | s a consequence of):                               |   |                                  |               |                               |                                    | Years  |
| min                              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Clease of Ajury that initiated events | HTN  |   |                                  |               |                               |                                    | Years  |
| EX                               | resulting in death) Last Due to (or a   | s a consequence of):                               |   |                                  |               |                               |                                    | Years  |
| edical Examiner                  | d   | ASCUT  | )   |                                  |               |                               |                                    | pec.   |
|                                  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcom   |  | □ Ectopic pregnanc  | y                                |               |                               | 23d. Date of o                     | lelivery<br>Day Year                                 |
| Completed by Physician/M         | 1   Yes 2   No 9   Unknown  | at time of death 5                                 | Other (specify) _   |                                  |               |                               | World                              | Day Tour   |
| y P                              | Part II. Other significant conditions contributing to death   | but not resulting in the u                         | underlying cause giv  | en in Part I                     |               | 23e. Did tob                  | pacco use contribute               | to the cause of death?                               |
| ted l                            |   |  |   |                                  | — J           | 1 □ Ye                        | s 2 No 3                           | Probably 4 Unknown                                   |
| nple                             |   |  |   |                                  | 1             | 24a. Was ar<br>autops         | v prior t                          | autopsy findings available<br>completion of cause of |
| Co                               | 25. Was case referred to medical  |  |   | 00 5:                            | -10           |                               | 2 <b>22</b> No 1 □ Y               | ?<br>es 2□No   |
| o Be                             | examiner?   | tient 2 ☐ ER/Outpatie                              | ent 3 DOA Oth   | OF:                              |               | Check only one<br>5 ☐ Reside  | e)<br>ence 6 □Other (S             | pecify)  |
| T:uc                             | 27. Manner of Death 1 Natural 5 Pending (Month, C   | njury 28b. Time o                                  |   |                                  |               |                               | w injury occurred                  |  |
| cati                             | 2 Accident investigation  |  |   | Yes 2 🗆                          |               | 1                             |                                    | D. J. Davida Musekan                                 |
| ertifi                           | determined   266, Place 01  | njury - At home, farm, st<br>etc. <i>(Specify)</i> | reet, factory, office   |                                  | 281           | City or Town                  |                                    | Rural Route Number,                                  |
| Medical Certification: To        | 29a. Certifier 1  | st of my knowledge, dea                            | th occurred at the ti   | me, date a                       | nd place, and | d due to the c                | ause(s) and manner                 | as stated.   |
| <b>Jedi</b> (                    | one) and manner   | stated.  | 200 Linear  | a number                         |               | 1 2                           | Od. Data signed (Ma                | oth Day Year)  |
|                                  | 29b. Signature and title of certifier   |  | 29c. Licens   | 2047                             | 01            | 2                             | 9d. Date signed (Mo                | nun, Day, Tear)                                      |
|                                  | 30. Name and address of person who completed cause of   | f death (Item 23a) (Type                           | , Print)  |                                  |               |                               | 5/27/0<br>Md 2121                  | 5  |
|                                  | SIH. MALINEN  |  | early Lak   | a a.                             | BA            | 170 M                         | nd 2121                            | 25   |
|                                  | 31. Date filed (MoVIII) Cay, Jean 2008 32 Pegis   | strar's Signature                                  | mente   |                                  |               |                               |                                    |  |
| te<br>ar                         | 31. Date filled (Month Lay, 2)ear, 2000   | strar's Signalure                                  | med !   |                                  |               |                               |                                    |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 20 2008 9:30AM M R. Gladys Jones May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 25 Glyndon Drive, Apt. Reisterstown Baltimore 8. Date of Birth (Month, Day, Year)
Jan. 13,1914 Birthplace (State or Foreign Country) 5. Social Security Number If Unde 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 💢 F Director 94 218-32-6558 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. At the state and Mental Hygiene with "natural", or items 23a or 28a-f show other traumatic event, the Medical Examine must be notified at 1 ☐ Yes 2 No Director Baltimore Reisterstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25 Glyndon Drive, Apt. T2 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2√☐No Specify Specify: Be Completed by 3 N Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sweetheart Cup Corp. assembly line worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John M. Pritt 2 Lizzie Morrison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara J. Jones Daughter in law | 11 Wolf Ave., Reisterstown, MD 21136 Pages 1 a. nent of Hea nt: If item 2 y or other 1 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page: Department o Important: If i any Injury or 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/23/08 Evergreen Mem. Gardens Finksburg, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 n Approximate Interval Between Onset and Death 23a. P rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest s ock, or heart failure. List only one cause on each line. edir te Cause (Final conj Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, physician Physician/Medical the SB attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has autopsy performed? 1 Yes 2 No certificate Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After t 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MO Reistanton ml 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Contin 13 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 8 2008 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** : 55AM 23 MAY 2008 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 12M 2□F Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f shov Examiner must be notified at 1 PYes 2 □No altimore Director 10g. Citizen of What Country? 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hyglene.
Item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) College,(1-4or 5+) Elementary/Secondary (0-12) other's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Location - City or Town. State 20c 20a. Method of Disposition Department of Himportant: If Ite any Injury or of 1 Burial 2 □ Cremation 3 □ Removal from State ARbstus Memorial 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNUEMONIA **Physician** /Medical Due to (or as a consequence of): Examine TCUTE CERE13RO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed ARTERIOSCLEROF and attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown VASCULA DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an RESSION autopsy performed? Yes 2 2 No DEMENT Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of s after death. 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide

Division or Vital Records, P.O. Box 68760,

completely filled in by the funeral To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 23300 MAY SELONRS 130N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) · 13A410 MD, 21223 SUPKIE 20. PATEL. 2000 W: 13A2TO.

State Registrar

31. Date filed (Month, Day, Year) MAY 2 8 2008

🖋 32. Registrar's Signature

08-03861 Donnell Jackson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 17195

|  |                 | or State   | Certificate of Death                       |                        |  |                                       | Reg. No.                  |                                    |                              |  |
|--|-----------------|--|--|------------------------|--|---------------------------------------|---------------------------|------------------------------------|------------------------------|--|
| Physician/   |                 | Decedent's Name (First, Middi                                    | ie,Last)                                   |                        |  |                                       |                           | Date of Death<br>Month Day         | Year                         | 3. Time of Death<br>1532 hrs                       |
| edical Examine   |                 | Donell   | Jacks                                      | 0h                     |  |                                       |                           | May 20, 2008                       | 0 1 1/0-1                    | <u> </u>   |
|  | 4a              | . Facility Name (if not institution                              |  |                        |  | Town, or Location                     | on of Death               |                                    | c. County of Dea             | n<br>A   |
|  |                 | Baltimore City Detenti   |  |                        |  | more                                  |                           | 8. Date of Birth (MI               | UDDAGGGG B                   | irthnlace (State or                                |
| Funeral  | 5.              | Social Security Number   | 6. Sex 7. Ag                               | e (In yrs. last bi     | rthday) If Und<br>Mont                 |                                       | Inder 24Hrs.<br>ours Min. | 8. Date of Birth (Mi               | Fore                         | ign A/   |
| Director   | 2               | 20-72-7051   | 1XM 2 F                                    | 15                     | Yrs.                                   | lis Days I                            |                           | May 5.                             | 1963                         | ountry) Va.  |
|  | U               | sual Residence of Decedent                                       |  |                        |  |                                       |                           |                                    |                              | 10d. Inside City Limits                            |
| any  | 10              | a. State 10b. County   |  | 10c. City, Tow         | n or Location                          | 1                                     |                           |                                    |                              | 1 Yes 2 No   |
| show   | -               | Md. I Ba   | Itimore                                    | Pil                    | Kesvi                                  | le                                    |                           |                                    |                              |  |
| a or 28a-f show  | 10              | e. Street and Number   | 0 1 0/                                     | Ar                     | 10f. Z                                 | p Code                                | -1                        | 109. 0                             | itizen of What Co            | ortity?  |
| death with the Maryland riems 23s or 28s-f sho must be notified at once.   | <u> </u>        | 1917 Cis   | ford Pla                                   | ace                    | A I                                    | 2120                                  | 8                         |                                    | US                           | π  |
| with the rs 23a pe noti  | <u>s</u> 1      | . Marital Status   | 12. Was Deceden                            |                        | 13. Was Dece                           | lent of Hispanic<br>cify Cuban, Mexi  | Origin? (Spe-             | cify Yes or No-<br>ican, etc.)     | 14. Race - Am<br>White, etc. | erican Indian, Black,                              |
| r death with or items 23   |                 | 7  | Married Armed Forces                       | No X                   |  |                                       |                           |                                    | D.                           | Lock   |
| العائية فق   | >l <sup>:</sup> |  | vorced If Yes, Give Yeer<br>or Dates:      |                        |  | 2 X No spe                            |                           | 146                                | Specify: 5                   | alleductor   |
| 215-0036 be filed within 72 hours after death with the Maryland mal Hygiene. rked other was "no ricens 23a or 28a-f 5the circle the Medical Examiner must be notified at once  |                 | 15. Decedent's Education (Spe                                    |  |                        | a. Decedent's Usua<br>during most of w | al Occupation (G<br>orking life. DO N | NOT use retire            |                                    | ). Killid of busines         | Silidostry   |
| 22 h = 12 h  | Completed       | Elementary/Secondary (0-12)                                      | ) College (1-4 or                          | 5+)                    | 1 1                                    |                                       |                           |                                    | Allonia                      | Produco  |
| o3(  | 틸               | 12   |  |                        | Lab                                    | DIEL                                  | ther's Name (             | First, Middle, Majd                | en Surname)                  | 5 HOARLE   |
| 5-0<br>lled w<br>Thygin  |                 | 7. Father's Name (First, Middle                                  | Last)                                      |                        |  | 10.1010                               | Mali                      | 10 P                               | rico                         |  |
| 21215-0036 hould be filed within 72 hours al and Mental Hygene. is marked other than "natural anservent, the Medical Examin  | a<br>R          | Trvin_   | Jackso Birth Inc                           | <u>'()</u>             | 19h Mailing Addre                      | ss (Street and                        | Number or Ru              | ral Route Number                   | City or Town, St             | ate, Zip Code) 2/208                               |
| Should and M   | <u></u> 1       | 9a. Informant's Name/Relation                                    | Stilp (Type, Fillit)                       | Son                    | 7907                                   | Pricto                                | ord f                     | LACE APT                           | Pikes                        | ville. Mail  |
| re, MD s 1 and 2 sho of Health and if item 27 is   | با              | 0a. Method of Disposition  | a Jaci                                     | 20b. Plac              | e of Disposition (N                    | ame of cemeter                        | y. ,                      | Date 20                            | c. Location - City           | or Town, State                                     |
|  | - 41            | Burial 2 Crematic  | on 3 Removal from S                        | State A cren           | natory or other place                  | (e)                                   | 115/2                     | 9/2008 I                           | 2,14                         | Md   |
| Pag<br>ment<br>fant:<br>or of  |                 | Donation 5 Other   |  | , IAcb                 | LITUS VI                               | e M.T. I                              | acility                   | 7 -00 [                            | Jan I.D.                     | 000  |
| Baltimore permit. Pages 1 a Department of He Important: If it injury or other t  | 2               | 1. Signature of Funeral S  | e Licenses                                 | 1111/                  | Josep                                  | 1 1 7 3                               | yss.                      | unera                              | Home                         | P.f.   |
|  | 1               | 3a. Part I. Enter the disease,                                   | or complications that cause                | of the death. Do       | not enter the mod                      | e of dying, such                      | as cardiac or             | respiratory arrest,                | shock, or heart              | Approximate Interval                               |
| Physician<br>the dical   | 1               | failure. List only one caus                                      | se on each line.                           |                        |  |                                       |                           |                                    |                              | Between Onset and<br>Death                         |
| aminer   |                 | mmediate Cause (Final diseas<br>or condition resulting in death) |  |                        |  |                                       |                           |                                    |                              |  |
|  | - 1             | _  | b.   | 1004201100 0171        |  |                                       |                           |                                    |                              |  |
|  | ا <u>ت</u>      | Sequentially list conditions, fany, leading to immediate         | Due to (or as a cor                        | nsequence of):         |  |                                       |                           |                                    |                              |  |
|  |                 | cause. Enter Underlying Caus<br>Disease or injury that initiated |  | oceaneace of).         |  |                                       |                           |                                    |                              |  |
| gi. g  | X               | events resulting in death) Las                                   |  | isequerice or).        |  |                                       |                           |                                    |                              |  |
|  |                 | UNPENDED   | d. X AMENDED                               | 222 5 /2               | . /00 —                                |                                       |                           |                                    |                              |  |
| 760, cate be ex physician he burial  | Medical         |  | AMENDED<br>#I, DETME<br>23c. If yes, outo  |                        |  |                                       |                           |                                    | 23d. Date of del             | very   |
|  |                 | F FEMALE:<br>3b. Was decedent pregnant in                        | the 1 Live birth                           |                        | 2 Fetal dea                            | ath 3 E                               | Ectopic pregna            | ncy                                | Month                        | Day Year   |
| Sox 687<br>death certific<br>e attending<br>for use as t   | icia            | past 12 months?  |  | at time of death       | 5 Other (S                             |                                       |                           |                                    |                              |  |
| Bo e deat  | $\sim$          |  | Jnknown 9 Unknown                          |                        | III                                    | des en les rives                      | o in Part I               | 23e. Did toba                      | cco use contribut            | e to the cause of death?                           |
| od by  | by P            | Part II. Other significant con                                   | ditions contributing to de                 | eath but not resu      | iting in the under                     | ing cause given                       | Intract.                  |                                    |                              | Probably 4 Unknown                                 |
| ires th  | 흸               |  |  |                        |  |                                       |                           | 24a. Was an                        |                              | e autopsy findings available                       |
| rds<br>requisional   | ig i            |  |  |                        |  |                                       |                           | autopsy                            |                              | r to completion of cause of                        |
| eco<br>ne lav<br>te has  | Completed       |  |  |                        |  |                                       |                           | 1 ✔ Yes 2                          |                              | Yes 2 No   |
| rtifica  |                 | 25. Was case referred to med                                     | ical                                       |                        |  |                                       | Death (Check              |                                    |                              |  |
| /ita   | o Be            | examiner? 1 Yes 2 No   | Hospital: 1 Inp                            | atient 2 E             | R/Outpatient 3                         | DOA                                   | ier <sub>4</sub> Nursir   | ng Home 5 R                        |                              | Other: Scene                                       |
| of \g Phy  | -1              | 27. Manner of Death  | 28a. Date of FOUND:                        | Injury 2<br>av.Year) . | 8b. Time of Injury                     | 28c. Injury at                        |                           | 28d. Describe ho<br>Subject assau  | w injury occurred<br>ulted   |  |
| on on ath.   | Ę               |  | May 20, 20                                 | 008   1                | FOUND:<br>1500 hrs                     |                                       | 2 <b>V</b> No             | ,                                  |                              |  |
| risic<br>r Atte<br>rer de<br>irecte  | 힐               |  | could not be May 20, 20                    | of Injury - At hom     | ne, farm, street, fac                  | tory, office build                    | ding, etc.                | 28f. Location (Str<br>or Town, Sta | eet and Number (<br>te) _    | or Rural Route Number, City<br>n 31, Baltimore, MD |
| Div<br>rrs afi   | Certification:  | 4 V Homicide   | etermined (Secify)                         | Jail/Penal             |  |                                       |                           |                                    |                              |  |
| Hospita<br>24 hours<br>Funeral   | 2               | 29a. Certifier 1 Certifying                                      | g Physian: To the best of                  | of my knowledge        | e, death occurred a                    | t the time, date a                    | and place, and            | due to the cause                   | (s) and manner as            | stated.  |
| Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certification and the former of the form. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as I | Medical         |  | Examiner: On the basis of and manner state | examination and<br>ed. | n/or investigation, i                  |                                       |                           |                                    |                              | (Month, Day, Year)                                 |
| _  | Me              | 29b. Signature and title of cer                                  |  |                        |  | 29c. License n                        |                           |                                    |                              |  |
| 8  |                 | / //   |  |                        |  | O.C.M.I                               | E.                        |                                    | May 21, 200                  |  |
| OCME   | 1               | 30. Name and address of pe                                       | n who completed cause                      | of death (Item 2       | ?3a)                                   |                                       |                           | 4D 04004                           |                              |  |
| OGIVIE   |                 | Mary G. Ripple Mo  | . Deputy Chief Me                          | edical Exam            | iner 111 Pe                            | enn Street, B                         | Baltimore, f              | VID 21201                          |                              |  |
| St   | ate             | 31. Date filed (Month, Day, Ye                                   |  | strar's Signatur       | 1.11                                   |                                       |                           |                                    |                              |  |
| Regist   | trar            | MAY 2 8  | ZUUO TAMEN                                 | 18 A SE                | parte                                  |                                       |                           |                                    |                              |  |
| DHMH 17 Rev 1/2  | 001             |  | -  |                        | ORIGINAL                               |                                       |                           |                                    |                              |  |

08-03903 Melissa Johnson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 17196

|  |                | 1 - For State<br>Registrar                                  |  | Cen   | tificate of                          | Death                                |   | Reg.   | No.   |  |
|--|----------------|---|--|---|--------------------------------------|--------------------------------------|---|--|---|--|
| Physicia<br>dical Exami  | ın/            |   | e (First, Middle, Last)                          | ( )   | ohnson                               |                                      |   | 2. Date of Death<br>Month Da<br>May 21, 200  | ay Year<br>8                                | 3. Time of Death<br>2105 hrs             |
|  |                |   | if not institution, give stre                    | eet and number)   | 41                                   | o. City, Town, o                     | or Location of Deat   | h  | 4c. County of Deat<br>Anne Arunde           |  |
| Funeral<br>Director  |                | 5220-78-5   |  | 7. Age (In yrs. Ia                                      | ist birthday)<br>Yrs.                | If Under 1 Ye Months Da              |   |  | MW/DD/YYYY) 9. Bi<br>-1960 Forei            | rthplace (State or<br>gn<br>puntry) Md 1 |
| ind<br>show any<br>nce.  | J.             | Usual Residence o   | 10b. County                                      | 10c. City,  | Town or Location                     | hma                                  | re  |  |   | 10d. Inside City Limits 1 Yes 2 No       |
| n the Maryls<br>3a or 28a-f<br>otified at o  | Director       | 10e. Street and Nu  | Bridge   | view Rd.  | Apt                                  | 10f. Zip Code<br>Zj                  | 225   | 10g.   | Citizen of What Co                          | A  |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once. | y Funera       | 11. Maritál Status  1 Never Marri  3 Widowed                |  | . Was Decedent Ever in U.s<br>Armed Forces?<br>Yes 2 No | If Ye                                |                                      | lispanic Ongin? ( S<br>an, Mexican, Puert<br>/<br>lo <i>specify</i> : |  | 14. Race - Ame<br>White, etc.               | Black,                                   |
| 56<br>n 72 hours a<br>nan "natura<br>ical Exami  | Completed by   | 15. Decedent's E  | ducation (Specify only h                         | ighest grade completed)  College (1-4 or 5+)            | during mo                            |                                      | ation (Give kind of<br>fe. DO NOT use re                              |  | 6b. Kind of Business HARB                   | OR TOLL                                  |
| 215-0036<br>e filed within all Hygiene.<br>ced other than  | Be Com         | 17. Father's Name   | (First, Middle, Last)                            | chuson  |                                      | Cara                                 | 000   | ne (First, Middle, Mai                       |   | ,  |
| MD 212<br>d 2 should be<br>Ith and Menta<br>n 27 is mark<br>umatic even  | ToE            | 19a. Informant's No.  | ame/Relationship (Type,                          | Print) USON - Son                                       | 3081                                 | Bee                                  | o Rd. F   | Backmi                                       | er, City or Town, Sta                       | . 21227                                  |
| Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 nijury or other traur   |                | 20a. Method of Dis<br>1 Burial 2<br>4 Donation 5            | Cremation 3                                      |   | 0                                    | er place)                            | Tory 5  | Date -30-08                                  | Cook Location - City of                     | e mo                                     |
| Baltimo<br>permit. Pag<br>Department<br>Important:<br>injury or of   |                | Marelan   | uneral Service Licensee                          | ions that caused the death.                             | 1 Na                                 | ame and Addre                        | Walle   | tos W. ( ce E.S.)  or respiratory arrest     | Frankli<br>Batto. M<br>I, shock, or heart   | Approximate Interval                     |
| /Medical<br>caminer  |                | failure. List by<br>Immediate Cause<br>or condition result  | hly one cause on each li<br>(Final disease a. Mu | ne. Itiple Injuries to (or as a consequence of          |                                      |                                      |   |  |   | Between Onset and Death                  |
|  | iner           | Sequentially list or if any, leading to it cause. Enter Und | mmediate Due<br>erlying Cause                    | to (or as a consequence of                              | f):                                  |                                      | <del></del>   |  |   |  |
| cuted md transit   | I Examine      | (Disease or injury events resulting in                      | n death) Last Due<br>d.                          | to (or as a consequence of                              |                                      |                                      |   |  |   |  |
| 760, Teate be executed physician and the burial - transit  | /Medical       | UNPENDE   |  | MENDED #1per M  |                                      | rFH G88                              | 32 8/15/0<br>————   | 98 TT  | Look Bath of Adition                        |  |
| Box 68760, e death certificate be the attending physic ed for use as the bur   | Physician/M    | IF FEMALE:<br>23b. Was decedended past 12 month             | t pregnant in the                                |   | 2 Fet                                | tal death S                          | 3 Ectopic preg  | nancy  | 23d. Date of delive                         | Day Year                                 |
| P.O. Es that the digned by the detached  | by             | Part II. Other sign   |  | ntributing to death but not re                          | esulting in the u                    | nderlying caus                       | e given in Part I.  |  |   | to the cause of death?                   |
|  | Completed      |   |  |   |                                      |                                      |   | 24a. Was an autopsy perform                  | prior t<br>ned? death                       |  |
| tal Recions: The certificate ector, page   | BeC            | 25. Was case refe<br>examiner?                              |  | oital:  |                                      |                                      | Other   |  |   |  |
| of Vit<br>ng Physic<br>ther this   | ပ              | 1 ✓ Yes<br>27. Manner of Dea                                | 2 No   | 28a. Date of Injury                                     | ER/Outpatient<br>28b. Time of Ir     |                                      | njury at Work?  |  | esidence 6 Otl                              | her: Scene                               |
| ion<br>eath.   | ation:         | 1 Natural 2 Accident  | 5 Pending Investigation                          | (Month, Day Year)<br>May 21, 2008                       | 2100 hrs                             | 1                                    | Yes 2 V No  | Pedestrian st                                | ruck by auto                                |  |
| 를 함 를 록  | Certification: | 3 Suicide 4 Homicide  | 6 Could not be determined                        | 28e. Place of Injury - At h<br>(Specify) Major Roa      | d / Highway                          |                                      |   | or Town, Sta<br>Route 2 and W                | ite)<br>arfield Road, Glei                  |  |
| To the Hospital within 24 hours To the Funeral completely fille  | Medical        | 29a. Certifier (Check only one) 2                           | Medical Examiner: Or                             | To the best of my knowled the basis of examination a    | ge, death occur<br>and/or investigat | red at the time,<br>tion, in my opin | , date and place, a<br>ion, death occurre                             | nd due to the cause<br>d at the time, date a | (s) and manner as s<br>nd place, and due to | tated.<br>the cause(s)                   |
| To<br>with   | Med            | 29b. Signature and  |  | d manner stated.  |                                      |                                      | ense number   |  | 29d. Date signed (#                         | Month, Day, Year)                        |
| $V_{i}$  |                | 30. Name and add  |  | pleted cause of death (Item                             |                                      |                                      |   |  | 22, 2000                                    |  |
| ×  | tate           | Carol Allan 31. Date filed (Moi                             | nth, Day, Year)                                  | Medical Examiner  32. Registrar's Signate               | ure                                  | Street, Balti                        | more, MD 212  | 201  |   |  |
| Reais  |                |   | MAY 2 8 200                                      |   | M Cono                               | 30 B. 1                              |   |  |   |  |

ORIĞINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death **Physician** Month May 24,2008 11:47P Deborah Ann Kirchner /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Balto.Co. Gilchrist Hospice Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funerai Months Days Hours 1 □ M 2 □ F 54 Director 213-60-4617 10-17-1953 Md Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exambles in the Invitio of the real traumatic event, the Medical Exambles in the Invitio of the content of the Invitor 1 ☐Yes 2☐No Director Md. Balto.Co. Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 69 Olde Forge Lane 21236 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - America Black, White, etc. White 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo 14. Race - American Indian, 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🗖 No If Yes, Give Year or Dates: þ Specify. 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Business\_Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Kues Teresa Weber ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) <u>Robert D. Kirchner Husband</u> 309 Talbot Court Abingdon. Md. 21009 20c. Location - City or Town, State permit. Pages 1 a
Department of He
Important: If item
any injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-27-2008 Bayview BAlto.Md. 21. Signatur 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancel montas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 

Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 📶 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director. After this certificate completely filled in by the funeral director, pag 2 □ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) NUSTLY 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie MMY 25 200P 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO 6701 N.

Chapter of Tonian m

DHMH 17 Rev 1/2001

State Registrar

CHANCES

32. Registrar's Signature

BANUN J. 31. Date filed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 18, 2008 1:10 AM M Dorothy Kearney 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Months Days Hours 1 ☐ M 2 🔯 F 218-28-9711 1934 Apr 22, 74 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County ty∑Yes 2 No Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21215 3011 Manhattan Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2🔀 No Specify black Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladys Kelley William Carrington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3110 Piedmont Avenue Baltimore, MD Brenda Lawson/sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Nonation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Konal C Baltimore, MD 21201 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme vate Cause (Final diseas or condition resulting in death) 40 Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off: Due to (or as a consequence of)

**Physician** /Medical Examiner

and

physician

**Physician** 

/Medical

**Examiner** 

10a State

MD

Director

Funeral

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Completed

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**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

altimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylam Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examine must be notified any Injury or other traumatic event, the Medical Examine must be notified any once.

Examine burial-trar Be Completed by Physician/Medical the attending pl ed by the a certificate has been signed by rector, page 2 should be detacl director, Medical Certification: To

Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 Mo 9 □ Unknown | 23c. If yes, outcome of pregnancy  1  | 23d. Date of delivery<br>Month Day Year   |
|---|---|---|
| Part II. Other significant conditions   | contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown |
|   |   | 24a. Was an autopsy performed? 1 □ Yes 2 □ No   |
| 25. Was case referred to medical  | 26. Place of Death (Ch  | neck only one)  |
| examiner?<br>1  Yes 2 No  | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home   | 5 ☐ Residence 6 COther (Specify) HOSPIE   |
| 27. Manner of Death<br>1 Matural 5 ☐ Pending<br>2 ☐ Accident investigat               | (Month, Day, Year) Injury Work?   | Describe how injury occurred  |
| 3  ☐ Suicide 6  ☐ Could no<br>4  ☐ Homicide determin                                  | a 28e. Place of Injury - At nome, farm, street, factory, office 28f. 1  | Location (Street and Number or Rural Route Number,<br>City or Town, State)                      |
|   | Physician: To the best of my knowledge, death occurred at the time, date and place, and aminer: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated |   |

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Name and address of person who comp

2008 28

32 Registrar's Signat

ted cause of death (Item, 23a) (Type, Print)

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1:05P M JOHN F. KRAUS MAY 25 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner OAK CREST VILLAGE NURSING HOME BALTIMORE COUNTY BALTIMORE If Under 1 Year | If Under 24 Months Days Hours 8. Date of Birth (Month, Day, Year) Jan. 10,1919 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** Months **X**□ M 2□ F Yrs 89 220~09~8516 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 3a or 28a-f show t be notified at 1 ☐ Yes 2 🛣 No Director Maryland | Baltimore Baltimore County 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21234 8832 Walther Blvd. Apt. 314 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Heath and Mehral Hygiens. In a marked them 20st Important: If Item 27 is marked other than "natural" or Items 20st any injury or other traumatic event, the Medical Examiner must Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXNo If Yes, Give Year or Dates; 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married XX Married White 1 ☐ Yes ŽŽ No Specify: Specify. Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A Yard Master Penna Railroad 12 should be filed w h and Mental Hygier 7 is marked other tl 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be <u>John L. Kraus</u> Katie M. Snyder 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14738 New Windsor Rd. New Windsor, Md. Carole Rommal (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. Joseph Ch. Cem. 5-31-2008 Fullerton, Md. 4 Donation 5 Dother (Specify) <sup>22</sup> Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21. Signature of Funeral Service Ligensee 20thou 21236 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician matastatic Cancer unknown primary /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ Ho 24a, Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28h Time of 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in hour. 2 ☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D18646 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Parleville

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) MAY 28 2008

32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and item 10e per fh 98/9 5-28-08 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Davd 1:30 22 Ma 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore LIVORIT Novyland Medical Lenter 0.4 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 9. Birthplace (State or Foreign Country) 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Vear) 214-62-8040 Usual Residence of Decedent 1 💢 M 2 🗆 F 954 South Carplina Director 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MOTA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò 212 2200 W. North Ave items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race -American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 6 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced lac "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, It s Me Elementary/Secondary (0-12) College (1-4or 5+) epreneur 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State awn Cemetery 22. Name and Address of Ficility Joseph L. Kus 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee Funera Hom Ave North Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fathere. List only one cause on each line. Hemorrhagic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequency of): Examiner sejosis Sequentially list conditions, way, leading to in maddate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transi and The law requires that the death certificate be exect Due to (or as a consequence of): Box 68760, ttending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day 5 Other (specify) the 1 ☐ Yes 2 ☐ No o detached 9 H Unknown signed by t I be detach σ. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? 1 □ Yes 2 No certificate 2 🗆 No of Vital 1 □ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division the Hospital or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May, 22, 2008 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shrartsbeyr Marianne 31. Date filed (Month, Day, Year) MAY 2 8 2008 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

MALL 08-03269

RICHARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| IK UNK   |               | State of Maryland / Department of Health and Mental Hygiene  -For State  Certificate of Death  Reg. No.  2008   720  |
|--|---------------|--|
| Physicia   | n/            | 1. Decedent's Name (First, Middle,Last)  2. Date of Death  Month  Day  Year  1455 hrs  |
| edical Examir  |               | Mark Richard Koppana April 28, 2008  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death   |
|  |               | 106 Dickens Street Glen Burnie Anne Arundel  |
| Funeral<br>Director  |               | 5. Social Security Number unk 6. Sex 1/2 M 2 F 7. Age (In yrs. last birthday) 49 Yrs. 1/2 Months Days Hours Min. Aug 31, 1958 9. Birthplace (State or Foreign Country)   |
| any  |               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  |
| and<br>show  | 5             | MD Anne Arundel Glen Burnie 1 Yes 2 X No   |
| death with the Maryland or items 23a or 28a-f show must be notified at once.   | Dire          | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  106 Dickens Street 21061 USA   |
| r death with<br>or items 23<br>must be no  | Funeral       | 11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  1 Yes 2 No  1 Vidowed 4 Divorced If Yes, Give Year  1 Yes 2 No  1 Yes 2 No Specify: White  |
| hours after death<br>'natural", or iten  | <u>a</u>      | 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work doneUnk 16b. Kind of Business/Industry Unk   |
| 36<br>in 72  | Completed     | Elementary/Secondary (0-12) College (1-4 or 5+)  unk unk  during most of working life. DO NOT use retired)   |
| D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica   |               | 17. Father's Name (First, Middle, Last)  unk  18. Mother's Name (First, Middle, Maiden Surname)  unk   |
| 21215-(<br>buld be filed v<br>Mental Hygi<br>marked oth<br>ic event, the   | To Be         | 19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)   |
| e, MD 2<br>and 2 should<br>fealth and M<br>item 27 is m  |               | O.C.M.E. 111 Penn Street Baltimore, MD 21201  20a. Method of Disposition   120b. Place of Disposition (Name of cemetery,   Date   20c. Location - City or Town, State  |
| More Pages 1 rent of H ant: If i   |               | 1 Burial 2 Cremation 3 Removal from State crematory or other place)  4 Constitute Specific In State  |
| Balti permit. Departm Imports injury o   |               | 21. Signature of Funeral Street Wade, Director State Anatomy Board 655 W. Baltimore Street  Reltimore MD 21201   |
| Physician  |               | Baltimore, MD 21201  23a. Rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and   |
| 'Medical<br>kaminer  |               | Immediate Cause (Final disease or condition resulting in death)  a. Atherosclerotic cardiovascular disease Due to (or as a consequence of):  |
|  | ē             | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |
| d d  | Examiner      | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  |
| executer<br>an and<br>and trans  | edical E      | d.  X UNPENDED  AMENDED  AMENDED  7/0/09 TT  |
| 60,<br>ate be ex<br>ohysician<br>te burial -   | Medi          | IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery   |
| Sox 68766<br>feath certificate<br>e attending phy<br>for use as the b  | sician/Me     | 23b. Was decedent pregnant in the past 12 months?   1 Live birth   2 Fetal death   3 Ectopic pregnancy   Month Day Year   4 Pregnant at time of death   5 Other (Specify)  |
| Box 6876<br>e death certificate<br>the attending phy<br>ed for use as the  | Physic        | 1 Yes 2 No 9 Unknown g Unknown   |
| ires that the signed by t  | by            | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown  |
| ords, w require s been sig   | Completed     | 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of   |
| eco<br>he law<br>ate has   | ошо           | performed? death? 1 ✓ Yes 2 No 1 ✓ Yes 2 No  |
| Vital Reco<br>ysician: The law<br>his certificate has<br>director, page 2 s  | BeC           | 25. Was case referred to medical examiner?   |
| f Vit<br>Physic<br>er this c   | To E          | 1 Yes 2 No Indistrict 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other Scene   |
| ion of tending Pheath.   | tion:         | 1 X Natural 5 Pending (Month, Day, Year) 1 Yes 2 No  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi | Certification | 2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide 1 Homicide 1 Route Number, Street, factory, office building, etc. (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  |
| Fo the Hosp<br>within 24 ho<br>To the Fune<br>completely f   | Medical C     | 29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |
| F 3 F 3  | Me            | 29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  O.C.M.E. April 29, 2008   |
|  |               | 30. Name and address of person who completed cause of death (Item 23a)   |
|  |               | Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201  31. Date filed (Month, Day, Year) 32 Registrar's Signature  |
| S<br>Regis   | tate<br>trar  | MAY 2 8 2008 Bloom, H. Roll .  |
| DHMH 17 Rev 1/2  | 2001          | ORIGINAL   |

State of Maryland / Department of Health and Mental Hygien 008

|                            |  |                  | Decedent's Name (First, Middle, La.   | st)  | Cen                                | ificate of                           | Death                                      |  | eg. No.           | 3. Time of Death   |
|----------------------------|--|------------------|---|--|------------------------------------|--------------------------------------|--|--|-------------------|--|
|                            | Physic   |                  | ALVIN   | S  |                                    | KIRS                                 | ΩN   | Month                                    | Day               | Year 11:56 pm  |
|                            | /Medi<br>Examii  |                  | 4a. Facility Name (If not institution, give   |  |                                    | KIKS                                 | 4b. City, Town, or Lo                      |  | 4c. County        |  |
|                            |  |                  | COLLEGE MANOR A   |  |                                    |                                      | LUTHERVIL                                  |  |                   | TIMORE   |
| Å                          | Funeral<br>Director  |                  | 5. Social Security Number 6. S 110-07-6598 11 Usual Residence of Decedent   | A  | s. last birthday)<br>38 Yrs.       | If Under 1 Year<br>Months Deys       |  | 8. Date of Birth<br>Month Day,<br>06/24/ | Ĭ909              | 9. Birthplace (State or Foreign Country) MD  |
|                            | yland<br>now   |                  | 10a. State 10b. County  | 10c. C   | City, Town or Loc                  | ation                                |  |  |                   | 10d. Inside City Limits  |
|                            | a Mar  | cto              | MD BALTIN   | ORE F  | PIKESVIL                           | LE                                   |  |  |                   | 1 ☐ Yes 2 🛣 No   |
|                            | ith th   | Director         | 10e. Street and Number  |  | "Made" Whee "Whee                  | 10f. Zip Code                        | ·  | 11                                       | 0g. Citizen of V  | What Country?  |
|                            | s 23s  | eral             | 11 SLADE AVENUE   |  | 110 10 10                          |                                      | 1208                                       |  | 144.5             | USA  |
| Maryland 21215-0020        | 72 hours after death with tha Maryland<br>natural", or Items 23a or 28a-f show<br>deal Examiner must be notified at  | by Funeral       | 11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced   | <ul><li>12. Was Decedent Ever in Armed Forces?</li><li>1 ∑Yes 2 ☐ No If Yes, Give Year or Dates:</li></ul> |                                    | as Decedent of I<br>Yes, specify Cub | Hispanic Origin? (Specian, Mexican, Puerto | Rican, etc.)                             |                   | e - American Indian,<br>ck, White, etc.<br>v: WHITE                                  |
| 15-0                       | in 72 hours<br>"natural",<br>ed cal Exz  | Be Completed     | 15. Decedent's Ed<br>(Specify only highest gra  | ucation<br>de completed)   | 16a. Decede                        | nt's Usual Occu                      | pation<br>during most of workind)          | ng                                       | 16b. Kind of Bu   | usiness/Industry   |
| 121                        |  | ig I             | Elementary/Secondary (0-12)   | College (1-4or 5+)   | life. D                            | NOT use retire<br>OWNER              | nd)  |  |                   | RETAIL   |
| d 2                        | filed<br>Hygir<br>other  | ပိ               | 17. Father's Name (First, Middle, Last)   | <u> </u>   |                                    | OWITEIN                              | 18. Mother's Name                          | (First, Middle, N                        | Лaiden Surnarr    |  |
| lan                        | should be filed with<br>and Mental Hygiana.<br>s marked other than<br>aumatic event, the h   | To B             | SAMUEL  |  | KIRSON                             |                                      | MARY                                       |  |                   | MILLER   |
| lan                        | d 2 should be filed within the and Mental Hygiene. 7 is marked other then traumetic event, I'm M   |                  | 19a. Informant's Name/Relationship (1   | ype, Print)  | 19b. Mailing                       | Address (Stree                       | t and Number or Rure                       | l Route Number                           | , City or Town,   | State, Zip Code)   |
|                            |  |                  | GLORIA KIRSON /   |  |                                    |                                      | NUE, #504,                                 |  |                   |  |
| Baltimore,                 | ant of the state o |                  | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specify   | Removal from State   | Place of Dispos<br>cemetery, cremi | atory or other pla                   |  | AY 25                                    | PALTIMO           | City or Town, Stete  ORE, MD   |
| Bal                        | pemit. 8 Departm Importar any injui  |                  | 21. Sighture of Funaral Service Licental Service Licental Licental Service Licental | 11101 -  | 89                                 |                                      | TERSTOWN R                                 | OAD, PI                                  | KEVILLE           | BROS., INC.<br>E, MD 21208   |
| >0°, ✓                     | Physician /Medical Examiner  bulksiclan and pulsiclan signature state private  | Medical Examiner | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury  | e. Conge Due to Atheri   | stive<br>(or as a consequ          | Hear ence of):                       | t Fai                                      |  |                   | Approximate Intervel Between Onset and Death   |
| . Box 68760,               | eath certif<br>attending<br>I for use a  |                  | that initiated events resulting in death) Last  | d  | or as e conseque                   |                                      | wan in Part I                              | 23h Did to                               | hacco use co      | ntribute to the cause of death?  |
| s, P.O.                    | s that tha d<br>jned by the<br>re detached   | by Physician/    |   |  | 2                                  |                                      |  |  | es 2□ No          | 3 Probably 4 Unknown   |
| Division of Vital Records, | e law requiras that<br>has been signed b<br>je 2 should be det   | Completed        | Multi The fav   | ct Deme  | ntig                               |                                      |  | 24a. Was ei<br>perform                   | n autopsy<br>ned? | 24b. Were eutopsy findings<br>aveileble prior to<br>completion of cause<br>of death? |
| alF                        | Page 1   | ខ                |   |  |                                    |                                      |  | 1 ☐ Ye                                   | s 2/2 No          | 1 ☐ Yes 2 ☐ No   |
| ξ                          | Physician:<br>this certific<br>ral director,   | o Be             | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No  | Hospital:  | 7500                               | Otl                                  | 26. Place of Death                         |  |                   |  |
| 10                         |  | n: To            | 27. Manner of Death   | 1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Dey Year)  | 28b. Time of                       | 3□ DOA 28c. Inju                     | 4 ⊔ Nursing Hor                            | ne 5∟Heside<br>28d. Describe ho          |                   | er (Specify) ASSISTE Living  |
| isior                      | Attanding Firdeath.<br>actor: After<br>by the funer  | Certification:   | 1 Anatural 5 Pending investigation 3 Suicide 6 Could not be determined  |  | Injury                             | M 1                                  | Yes 2 □ No                                 | 28f. Location (St                        | reet and Numb     | er or Rural Route Number,  |
| ă                          | To the Hospital or Attandi<br>within 24 hours after death.<br>To the Funaral Director: A<br>completely filled in by the fi   |                  | 4   Homiciae  | building, etc. (Spec   | ify)                               |                                      |  | City or Town                             | , State)          | 30- 91 118-4-1   |
|                            | e Hoe  | edical           | (Check only 2 Medical Exem  | Iner: On the basis of exemin<br>end manner stated.   | etion end/or Inve                  | stigation, in my                     | opinion, deeth occurre                     | ed et the time, da                       | ate and place,    | and due to the ceuse(s)  |
|                            | To th<br>withir<br>To th<br>comp   | ž                | 29b. Signature and title of certifier   |  |                                    | 29c. Licens                          | se number                                  | 29                                       | 9d. Date signer   | d (Month, Day, Year)   |
|                            |  |                  | 1 pl  | (m MD)   |                                    | DS                                   | 57444                                      |  | 5/23              | 3/2008   |
|                            | 6  |                  | 30. Name and address of person who o  |  | m 23a) (Type, P                    | rint)                                | 19099                                      | 1.21.10                                  | 1 - 1             | 71264  |
|                            |  |                  | Alexander W. (31. Date filed (Month, Day, Yeer)   | Registrar's Sign   | nature -                           | JOX                                  | 1074                                       | 10 wson,                                 | 10                | 01054  |
|                            | Sta  | ie.              | MAY 2 8 2008  |  | 1 Acar                             | 2.                                   |  |  |                   |  |

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 24, 2008 Year **Physician** 2:25 рм Hyun Soo Lee /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Casey House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 6, 1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 M 2 □ F 63 Director 215-84-1136 Korea Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ral", or items 23a or 28a-f shore Examiner must be notified at Rockville 1 ☐ Yes 2 No MD Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with USA 20850 1709 Redgate Farms Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hyglene. ant: If Item 27 is marked other than "natural", or iten ury or other traumafte event, the Medical Examinet 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify: Specify: Asian 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Space Science Machinist 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pan Oak Kim Hyung Kyu Lee ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1709 Redgate Farms Court, Rockville, MD 20850 James Lee-son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 5/28/2008 Silver Spring, MD 21. Signature of Funeral Serv Rapp Funeral Facilit Cremation Svcs. M00382 Rapp Funeral & Cremation Svo.

933 Gist Ave. Silver Spring,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 933 Gist Ave. Silver Spring, MD 20910 Immediate Cause (Final disease or condition resulting in death) Physician Lung cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or in jury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, burial-transi Due to (or as a consequence of) physician Physician/Medical the as attending p IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Tectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signe should be a þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No rectificate has birector, page 2 s 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Mother (Specify) Hospice Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2**7** No 1 ☐ Yes P 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 5/24/2008 D0064615 ne and address of person who completed cause of death (Item 23a) (Type, Print) MUNEASTER MILL RO, ROCKVILLE MD M.D (000) CHENEVINE NROBLEWSKI 32 Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 Month **Physician** 24,\_ 3:36 A.M Douglas Lee Leftwich Jr. May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Gilchrist Hospice Baltimore Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Months Days Min. ty⊠tM 2□ F 21, 1921 Balt., 215-10-2826 87 May Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be puffled and once. 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore 10g, Citizen of What Country? United States 10f. Zip Code 10e. Street and Number ō 6131 North Charles Street 21212 of America Funeral 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 12 DXYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1∐Yes 2∭2No Specify: Specify: white þ ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Glen L. Martin Buyer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas Lee Leftwich Sr. Edna Walker ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Douglas L. Leftwich III/ son 5125 Richardson Drive Fairfax, Virginia 22032 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral
Chapel—Bel Air 20c. Location - City or Town, State 20a. Method of Disposition May 28, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

21. Signature (Superal Service Licensee) Forest Hill, Maryland 2008 22. Name and Address of Facility Peaceful Alternatives Funeral & Cremation Ctr., 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that of used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** YENS disease or condition resulting in death) Schimic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of). P.O. Box 68760, physician Physician/Medical the attending plant for use as as IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Year signed by the at the detached for 5 Other (specify) □Yes 2□No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s autopsy performed? 1 Yes 2 1000 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) WOS 7 CP 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this y filled in by the funeral di Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a 🗁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature of title of certifier 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MON Charles TOWSIN NO 2 1204 1, MANUES wo 6701 31. Date filed (Month, Day, Year) ■ gistrar's Signature

ORIGINAL

32

28

DHMH 17 Rev 1/2001

State

Registrar

| aron Longus   |               | 1- For State<br>Registrar   |  |                       | t of Health and Mei<br>of Death                                  |                    | Reg. No                               | 200                                     |  |
|---|---------------|---|--|-----------------------|--|--------------------|---------------------------------------|---|--|
| Physici<br>ledical Exami  |               | 1. Decedent's Name (First, Mid<br>Aaron   | McNei  | .1                    | Longus Sr  | Mo                 | te of Death<br>onth Day<br>y 25, 2008 | Year                                    | 3. Time of Death<br>1032 hrs                       |
| · **  |               | 4a. Facility Name (if not institut<br>4511 Groveland Ave  |  |                       | 4b. City, Town, or Location<br>Baltimore                         | n of Death         |                                       | c. County of Death                      |  |
| Funeral<br>Director   |               | 5. Social Security Number 218-60-4022   | 6. Sex 7. Age (                                  | (In yrs. last birthda | y) If Under 1 Year If Under 1 Year Amonths Days Hou              | rs Min.            | ate of Birth (MM)                     |   | hplace (State or Foreign Intry) MD                 |
| any   | }             | Usual Residence of Decedent<br>10a. State 10b. Count  | , <u> </u>                                       | 0c. City, Town or L   |  |                    |                                       |   | 10d. Inside City Limits                            |
| daryland<br>28a-f show  | ō             | MD N  | A  | Ва                    | ltimore  |                    |                                       |   | 1 X Yes 2 No                                       |
| with the Maryland ns 23a or 28a-f sho be notified at once.  | I Director    | 10e. Street and Number 4511 Grovel  |  |                       | 10f. Zip Code<br>21215   |                    |                                       | itizen of What Cour                     |  |
| or iter   | Fune          | 11. Marital Status 1 Never Married 2 X 3 Widowed 4 D  | Married 12. Was Decedent E Armed Forces? 1 Yes 2 | ver in U.S. 13        | 8. Was Decedent of Hispanic On If Yes, specify Ouban, Mexica     | an, Puerto Rican   |                                       | 14. Race - Americ White, etc.  Specify: | can Indian, Black,                                 |
| hours af<br>natural<br>Examin   | eted by       | 15. Decedent's Education (Sp  | lor Dates:<br>pecify only highest grade comp     | duri                  | edent's Usual Occupation (Given most of working life. DO NO      | e kind of work do  | one 16b                               | . Kind of Business/I                    | ndustry  |
| 5-0036<br>led within 72 hours after<br>Hygiene.<br>other than "natural",<br>the Medical Examiner  | nplet         | Elementary/Secondary (0-12 12th grade   | College (1-4 or 5+                               | )                     | System Techn   |                    |                                       | Verizo                                  | on   |
| MD 21215-0036 at 2 should be filed within 7 at 2 should be filed within 7 at and Mental Hygiene. In 27 is marked other than anumatic event, the Medica                | 9             | 17. Father's Name (First, Midd  |  |                       |  | er's Name (First   |                                       | en Surname)                             |  |
| 212'<br>uld be<br>Mental<br>marke   | To Be         | Robert Long 19a. Informant's Name/Relation  |  | 19b. M                | lailing Address (Street and Nu                                   | _                  |                                       | City or Town, State                     | , Zip Code)  |
| MD<br>d 2 sho<br>th and<br>n 27 is<br>numation  | 1 1           | Sheila Long   | us-Wife  | 4                     | 511 Grovelan   | nd Ave,            | Balt                                  | imore, N                                | 1d 21215   |
| Baltimore, MD 2121<br>permit. Pages I and 2 should be fil<br>Department of Health and Mental I<br>Important: If item 27 is marked<br>injury or other traumatic event, |               | 20a. Method of Disposition  1 X Burial 2 Cremati  | on 3 Removal from State                          | crematory             | isposition (Name of cemetery, or other place)                    | Date               |                                       | c. Location - City or                   |  |
| Iltim<br>nit. Pa<br>artmen<br>bortant<br>rry or c   |               | 4 Donation 5 Other 21. Signature of Funeral Service   |  |                       | emorial Park<br>22.Name and Address of Facil<br>March F/H We     |                    | 78                                    | Woodlas                                 | VII, FIG   |
|   |               | Rrome   | Thumps   | an i                  | 4300 Wabash  | Ave, E             | Baltim                                | ore, Md                                 | 21215  |
| Physician<br>/Medical   | J y           | 23a. Part I. Enter the disease, failure. List only one caus                                       | se on each line.                                 |                       |  | s cardiac or respi | iratory arrest, s                     | hock, or heart                          | Approximate Interval<br>Between Onset and<br>Death |
| -xaminer  |               | Immediate Cause (Final diseas<br>or condition resulting in death)                                 |  |                       | & cocaine use  |                    |                                       |   | Death  |
|   | Ļ             | Sequentially list conditions,   | b. Due to (or as a conseq                        |                       |  |                    |                                       |   | ļ  |
|   | Examiner      | if any, leading to immediate<br>cause. Enter Underlying Caus<br>(Disease or injury that initiated | C  |                       |  |                    |                                       |   |  |
| nted<br>d<br>ansit  |               | events resulting in death) Las  |  | uence of):            |  |                    |                                       |   |  |
| 68760,<br>certificate be executed<br>nding physician and<br>ise as the burial - transit   | Aedical       | XINPENDED   | X AMENDED  | 07.00                 |  |                    |                                       |   |  |
| 760, icate be physic the buri   | /Me           | IF FEMALE:<br>23b. Was decedent pregnant in   | the  | of pregnancy          | erMF,g880 6/12/08  |                    | 2                                     | 23d. Date of deliver                    |  |
| Box 6876<br>e death certificat<br>the attending phed for use as the   | Physician/    | past 12 months?   | 4 Pregnant at til                                | me of death 5         | Fetal death 3 Ector Other (Specify)                              | pic pregnancy      |                                       | Month [                                 | Day Year   |
| he d  | Phys          | Part II. Other significant cond   | 9 Unknown  | but not resulting in  | the underlying cause given in                                    | Part I.            | 23e. Did tobaco                       | co use contribute to                    | the cause of death?                                |
| , P.O, res that the signed by be detac  | d by          | Emphysema   |  |                       |  |                    | 1 Yes 2                               | No 3 Pro                                | pably 4 🗸 Unknown                                  |
| of Vital Records,<br>g Physician: The law requir<br>ther this certificate has been s<br>meral director, page 2 should l   | Completed by  |   |  |                       |  |                    | 24a. Was an<br>autopsy                | prior to d                              | topsy findings available completion of cause of    |
| Reco  | mo.           |   |  |                       |  | 1                  | performed<br>✓ Yes 2                  | ? death?<br>No 1 🗸 Ye                   | es 2 No  |
| tal Rei<br>ician: The<br>certificate<br>rector, pagi  | Be            | 25. Was case referred to medie examiner?  | Hospital:  |                       | 26.Place of Dear   |                    |                                       |   |  |
| of Vital ling Physician: After this certif  | P             | 1 ✓ Yes 2 No<br>27. Manner of Death   | 28a. Date of Injury<br>(Month, Day,Yea           |                       | atient 3 DOA Citie 4 e of Injury 28c. Injury at Wo               |                    | Describe how i                        | dence 6 Othe                            | r: Scene   |
|   | tion          |   | nding  |                       | 1 Yes 2  | X No u             | nk                                    |   |  |
| Division<br>pital or Attendi<br>ours after death.<br>eral Director:   | ertification: | 3 Suicide 6 X Co  | ula not be                                       |                       | , street, factory, office building,                              |                    | Location (Stree                       |   | iral Route Number, City                            |
| 15 6 00 Fig.  | O             | 4 Homicide  |  | me                    |  | 451                | 1 Grovel                              | and Ave. Ba                             | ltimore, MD  |
| To the Hos<br>within 24 h<br>To the Fun   | Medica        | FCkeck only   Certifying  | caminer: On the basis of exami                   |                       | occurred at the time, date and pastigation, in my opinion, death |                    |                                       |   |  |
| 5 wit as  | Me            | 29b/Signature and title of certi  | and manner stated.                               |                       | 29c. License numbe   | er                 | 29                                    | d. Date signed (Mo                      | nth, Day, Year)                                    |
|   |               | Ukulisle  | ul   |                       | O.C.M.E.   |                    | M                                     | ay 26, 2008                             |  |
|   |               | 30. Name and address of person Laron Locke MD.  | on who completed cause of dea                    | , ,                   | Penn Street, Baltimore,  | MD 21201           |                                       |   |  |
| <u>s</u>  | tate          |   |  |                       | The Carotty Balantoro,   |                    |                                       |   |  |
| Regis   | trar          | MAY 2 8 2   | 008  | H. As                 |  |                    |                                       |   |  |
| DHMH 17 Rev 1/2   | 001           | 00115   | •  | OPIC                  | INIAL  |                    |                                       |   |  |

|          |   | •              | For<br>State<br>Reglstrar   | State of Mary                                    | rand / Depa<br><i>Cer</i> | rtificate of L                             | Death                                   | rental myg                       | leg. No. 2008                             | 17206   |
|----------|---|----------------|---|--|---------------------------|--|---|----------------------------------|---|---|
| i<br>P   | Physicia  | an             | 1. Decedent's Name (First, Middle, La   | st)  |                           |  |   | 2. Date of Dea                   | Day Year                                  | 3. Time of Death                                    |
|          | /Medic  | al.            | Hans Robert La  |  |                           | 4h City Tourn or                           | Location of Death                       | IVIAY                            | 2   , 200<br>4c. County of Dea            |   |
|          | Examin  | er             |   | •  |                           | Westmins                                   |   |                                  | Carro                                     |   |
|          | Funeral   |                | Carroll Hospita: 5. Social Security Number 6. S   | Sex 7. Age (II                                   | n yrs. last birthday)     |  | If Under 24 Hrs. Hours Min.             | 8. Date of Birth<br>(Month, Day  | 9. Bir                                    | thplace (State or Foreign                           |
|          | Director  |                | 213-28-6628   | M 2□F 8  | 2 Yrs.                    | Mortins Days                               | Hours Will.                             | Feb. 27                          |   | MD  |
|          | and<br>w  |                | Usual Residence of Decedent  10a. State 10b. County   | 10   | c. City, Town or Lo       | cation                                     |   |                                  |   | 10d. Inside City Limits                             |
|          | Maryl<br>f sho<br>ied al  | 5              | MD Carrol   | 17   | T24 1-                    | -1   |   |                                  |   | 1 □Yes 2√∑No  |
|          | r 28a-  | Director       | 10e. Street and Number  | L.L.   | FINK                      | 10f. Zip Code                              |   | 1                                | 10g. Citizen of What Co                   | ountry?   |
|          | th with   |                | 2510 Appaloosa  | Way  |                           |  | 21048                                   |                                  | USA                                       |   |
|          | r dea<br>tems<br>er mi  | Funeral        | 11. Marital Status  | 12. Was Decedent Ever<br>Armed Forces?           | r in U.S. 13. \           | Was Decedent of Hi<br>If Yes, specify Cuba | ispanic Origin? (Span, Mexican, Puerto  | ecify Yes or No-<br>Rican, etc.) | 14. Race - Ame<br>Black, Whi              |   |
| 20       | rs afte   | by F           | 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced  | 1 ¥ Yes 2 □ No<br>If Yes, Give<br>Year or Dates: |                           | 1 ☐ Yes 2 🗓 No                             | Specify:                                |                                  | Specify:                                  | Thite   |
| -0030    | 72 hours after death with the Maryland<br>natural", or Items 23a or 28a-f show<br>dical Examiner must be notified at  |                | 15. Decedent's E  | ducation   | 16a. Deced                | dent's Usual Occupa                        | ation                                   |                                  | 16b. Kind of Business                     |   |
| 2        | 12 should be filed within 7/<br>h and Mental Hygiene.<br>7 is marked other than "n<br>fraumatic event, the Medi   | Completed      | (Specify only highest gra<br>Elementary/Secondary (0-12)  | College (1-4or 5+)                               | life. L                   | kind of work done o<br>DO NOT use retired  | during most of work<br>()               | ing                              |   |   |
| 7        | ed wi   |                | 8   |  |                           | Clerk                                      | 40 Markada Nasa                         | - /F:                            | Noxe1                                     |   |
| ana      | be fil  | Be             | 17. Father's Name (First, Middle, Last  |  |                           |  | 18. Mother's Name                       | , , ,                            | Maiden Surname)                           |   |
| Ž        | should<br>nd Me<br>mark<br>matic  | ٩              | Hans Robert Lamp  19a. Informant's Name/Relationship  |  | 19b. Mailir               | na Address (Street a                       |   | Kendig                           | r, City or Town, State,                   | Zip Code)   |
| <u>a</u> | and 2 sealth ar n 27 is ier trau  |                | Mary R. Stroh   | Niece  |                           | Dyer Ave.                                  |   |                                  |   | , ,   |
| ה<br>ה   | of Hear   |                | 20a, Method of Disposition  | 2  | 20b. Place of Dispo       |  |   | Date                             | 20c. Location - City or                   | Town, State   |
|          | Pages<br>nent of<br>ant: If it<br>ury or o  |                | 1 XBurial 2 □ Cremation 3 □<br>4 □ Donation 5 □ Other ( <i>Speci</i>  | JRemoval from State                              | Garrison                  |  | 1                                       | 28/08                            | Owings Mi                                 | .11s, MD  |
| Банттог  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                | 21. Signature of Funeral Service Lice   | nsee .   | 1                         | 2. Name and Addres                         |   |                                  | Reistersto                                |   |
|          | 20 = e O  |                | 22a Port 1 Enter the diseases or com  | entioptions that agreed the                      |                           | line Fune                                  |   |                                  | erstown, MD                               | 21136 Approximate                                   |
|          |   |                | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final                             |  |                           |  |   |                                  | 1631,                                     | Interval Between<br>Onset and Death                 |
|          | Physician<br>/Medical   |                | disease or condition resulting in death)  | a. CLOSTA<br>Due to (or as a co                  |                           | DIFFICK.                                   | E (0                                    | 21713                            |   |   |
|          | Examiner  |                | 1   | Due to for as a co                               | orisequence ory.          |  |   |                                  |   |   |
| ļ        | T = #   | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or injury that initiated events | Due to (or as a co                               | onsequence of):           |  |   |                                  | .0.                                       |   |
|          | ecuted<br>ind<br>transi   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last   | C  |                           |  |   |                                  |   |   |
| SC.      | be exician a  |                | Tobaling in doubly Educ   | Due to (or as a co                               | onsequence or):           |  |   |                                  |   |   |
| 20/00,   | ficate be executed<br>I physician and<br>Is the burial-transit  | edical         |   | ▲d   |                           |  |   |                                  |   |   |
|          |   |                | IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome pf                          |                           | 7  |   |                                  | 23d. Date of de                           | elivery   |
| 0        | law requires that the death certi<br>as been signed by the attending<br>2 should be detached for use a  | Physician/M    | in the past 12 ponths?<br>1 ☐ Yes 2 ☐ No  | 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim           |                           | ∃Ectopic pregnancy<br>∃Other (specify)     | ·                                       |                                  | Month                                     | Day Year  |
| 5        | at the<br>by th   | hys            | 9 ☐ Unknown   | 9□Unknown  |                           |  |   |                                  |   |   |
| Ď.       | res th  | by F           | Part II. Other significant conditions   | contributing to death but n                      | ot resulting in the u     | nderlying cause give                       | en in Part I.                           |                                  | obacco use contribute t<br>'es 2 No 3 ☐ F | o the cause of death?                               |
| ecords   | requi   | sted           |   |  |                           |  |   |                                  |   |   |
| ב<br>ב   | a av  | Completed      |   |  | <u>-</u>                  |  |   | 24a. Was a<br>autop              | an 24b. Were a prior to death?            | utopsy findings available<br>completion of cause of |
| VII      | sician: The law<br>certificate has be<br>lirector, page 2 s   | e Co           | 25. Was case referred to medical  | T  |                           |  | OC Plans of Door                        | 1□ Yes                           | 2 No 1 □Ye                                | s 2 No  |
| 5        | ysicia<br>s cert  | 0 B            | examiner?   | Hospital: Impatient                              | 2 ☐ ER/Outpatier          | nt 3 DOA Othe                              | 26. Place of Deat<br>er: 4 □ Nursing Ho |                                  | lence 6 □Other (Spe                       | ecify)  |
| 0        | ig Phy<br>ter thi   | $\vdash$       | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Ye            | 28b. Time o               |  |   |                                  | now injury occurred                       | ,   |
| VISION   | endin<br>eath.<br>or: Af<br>he fur  | atio           | 1 Natural 5 Pending investigatio  | n  | , injury                  |  | Yes 2 □ No                              |                                  |   |   |
| <u>=</u> | or Att<br>fler de<br>Sirect<br>in by t  | Certification: | 3 Suicide 6 Could not be determined   |  |                           | reet, factory, office                      |   | 28f. Location (S<br>City or Tow  | Street and Number or F<br>vn, State)      | lural Route Number,                                 |
| 2        | pitai<br>ours al<br>erai C  |                | 29a. Certifier 1 Certifying P   | hysician: To the best of m                       | v knowledge deat          | h occurred at the tir                      | me date and place                       | and due to the                   | cause(s) and manner a                     | s stated  |
|          | 24 ho<br>24 ho<br>Fun<br>etely  | Medical        |   | miner: On the basis of ex<br>and manner stated   | amination and/or in       |  |   |                                  |   |   |
|          | To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, page:  | Me             | 29b. Signature and little of certifier  | 4  |                           | 29c. License                               | e number                                |                                  | 29d. Date signed (Mor                     | th, Day, Year)                                      |
|          | (1)   |                |   | MD   |                           | Doc  | 55955                                   | 2                                | May 21                                    | , 2008  |
| - 1      | IVI   | 1              | 30. Name and address of person who  | completed cause of death                         | h (Item 23a) (Type.       | Print)                                     |   |                                  |   | 4   |
| ı        | 11.   |                |   | completed cause of deat                          |                           | 10 011                                     | Fermin                                  | Tra na                           | 10 21150                                  |   |
| ,        | Sta   |                | 30. Name and address of person who COURSH Putters 31. Date filed (Month, Day, Year)   | C-NACANNA 32. Registrar's                        | 700A Pos                  | de Rd U                                    | NESTAINS,                               | TER M                            | 0 21157                                   |   |

DHMH 17 Rev 1/2001

|                   |  | •              | For State Amend 9,11,12,15,1  | State of Mary<br>.6a-b,17,18,1   | /land/Depa<br>l9a-b,20 <i>0ei</i> | rtment of He<br>122 perFH<br>tificate of D                   | ealth and M<br>\$80,6/5/08<br>reath                 | ental Hygie                           | ene 2008   | 17207  |
|-------------------|--|----------------|---|--|-----------------------------------|--|---|---------------------------------------|--|--|
|                   | Physicia   | an             | Decedent's Name (First, Middle, Last)   |  |                                   |  |   | 2. Date of Death<br>Month             | Day Vear   | 3. Time of Death                                   |
| No.               | /Medic   | al             | Walter LeClaire  4a. Facility Name (If not institution, give str                                | reet and number)   | - 1                               | 4b. City, Town, or L   | ocation of Death                                    | Mag                                   | 16 2008<br>4c. County of Death                     | 7.50/2   |
|                   | Examin   | er             | Genesis Loch Rav  |  |                                   | Baltimo  | ore   |                                       | Baltimor   |  |
| li                | Funeral<br>Director  |                | 001-01-0490   | M 2 1 E  | n yrs. last birthday)<br>90 Yrs.  | If Under 1 Year<br>Months Days                               | Hours Min.  | 8. Date of Birth (Month, Day, Nov 13, | Year) Coui   | place (State or Foreign ntry) unk                  |
|                   | land<br>ow   |                | Usual Residence of Decedent  10a. State 10b. County   | 10   | Oc. City, Town or Lo              | cation   | -   |                                       | 1  | 10d. Inside City Limits                            |
|                   | Mary<br>a-f sho<br>ified a   | ctor           | MD Baltimo  | re   | Baltimo                           | ore  |   |                                       |  | 1 □Yes 2□No  |
|                   | th with the<br>23a or 28<br>ist be not   | al Director    | 10e. Street and Number<br>8720 Emge Road  |  |                                   |  | .234  |                                       | g. Citizen of What Coul USA                        |  |
| 036               | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 11. Marital Status unk 12  1 □ Never Married 2 □ Married  3 ▼ Widowed 4 □ Divorced              | 2. Was Decedent Eve<br>Armed Forces?<br>1X Yes 2 No<br>If Yes, Give<br>Year or Dates: WW | unk                               | Was Decedent of His<br>f Yes, specify Cubar<br>I □ Yes 2X No | panic Origin? (Spe<br>, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)      | 14. Race - Americ<br>Black, White,<br>Specify: whi | etc.   |
| 2-0               | 72 hor   | eted           | 15. Decedent's Educa<br>(Specify only highest grade   | ation<br>completed)  | (Give                             | dent's Usual Occupa<br>kind of work done di                  | ıring most of worki                                 |                                       | 6b. Kind of Business/In                            | dustry <del>unk</del>                              |
| 21215-0036        | within<br>ene.<br>than "   | Completed      | Elementary/Secondary (0-12) unk 12  | College (1-4or 5+)   | Store N                           | 00 NOT use retired)<br>Manager                               |   |                                       | Agway  |  |
| <b>d</b> 2        | il Hygi<br>other<br>ent, tl  | Be Co          | 17. Father's Name (First, Middle, Last)   |  | , 50070 .                         |  | 18. Mother's Name                                   | (First, Middle, M                     |  | -unk   |
| /lan              | Menta<br>Menta<br>arked<br>atic ev   | To B           | Edmund LeClair  |  |                                   |  | Marion Una  |                                       |  |  |
| Maryland          | 12 sho<br>h and<br>7 Is ma<br>trauma   |                | 19a. Informant's Name/Relationship (Type<br>Genes is Loch, Rav                                  |  | 19 <b>1.31</b> 111                | o Address ( <i>Street a.</i><br>20 Enge Ro                   | Hawley or PA  | 18428 MR                              | City or Town, State, Zi <sub>i</sub>               | p Code)  |
|                   | Healt<br>tem 2   | 1              | Barry P. LeClair / Son<br>20a. Method of Disposition  |  | 20h Place of Dispo                |  |   |                                       | Oc. Location - City or T                           | own, State   |
| E E               | Pages<br>tent of<br>int: If I  |                | 1 Burial 2 □ Cremation 3 □ Re<br>4 □ Donation → Aother (Specify)                                |  | Whispering N                      | Maples Mem.  | 6/6/  | 2008                                  | Ellenburg Depo                                     | ot, NY   |
| Baltimore,        | permit. Departn Importa any Inju   |                | 21. Signature of Funeral Scale License Restard Scale  | ale Direc  | tor                               | Name and Address   | THE ROOM  |                                       | . 8521 Foch R<br>MD 21280                          | sven Klvd.<br>Street                               |
|                   |  |                | 23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one              | ations that caused the cause on each line.   | e death. Do not ent               | er the mode of dying   | , such as cardiac                                   |                                       |  | Approximate<br>Interval Between<br>Onset and Death |
| 8                 | Physician  |                | Immediate course (Final disease or condition resulting in death)                                | 4  |                                   | MMA  | 2   |                                       |  |  |
|                   | /Medical<br>Examiner   |                |   | Due to (or as a  | onsequence of):                   | •  |   |                                       |  |  |
| 4                 | 8°   | ner            | Sequentially list conditions, if any leading to immediate cause. Enter I Inderlying             | Due to (or as a c  | consequence of):                  |  |   |                                       | 19   |  |
|                   | ecuted<br>ind<br>transit   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |                                   |  |   |                                       |  |  |
| 68760,            | ficate be executed<br>physician and<br>the burial-transit  | al E           | resoning in doddiny addition  | Due to (or as a c  | consequence or).                  |  |   |                                       |  |  |
| 687               | ificate<br>g phys  | edical         | d.  |  |                                   |  |   |                                       |  |  |
| P.O. Box          | The law requires that the death certificate has been signed by the attending page 2 should be detached for use as  | Physician/M    | IF FEMALE: 23 b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown        | tc. If yes, outcome pf<br>1□Live birth 2<br>4□Pregnant at tir<br>9□Unknown               | ☐ Fetal death 3 ☐                 | □Ectopic pregnancy<br>□ Other (specify)                      |   |                                       | 23d. Date of delive Month                          | very<br>Day Year                                   |
|                   | es that i<br>gned by<br>be deta  | by Ph          | Part II. Other significant conditions conf  | tributing to death but   | not resulting in the u            | nderlying cause give   | n in Part I.  | 23e. Did tob                          | eacco use contribute to                            | the cause of death?                                |
| ord               | requir   | eted           | 1   | ) WS to  | to /                              | an (QH   |   | 24a. Was ar                           |  | topsy findings available                           |
| Records,          | e la<br>has  | Completed      |   | 103/11   | 16                                | O(p) (see  |   | autops                                | y prior to c<br>ned2 death?                        | ompletion of cause of                              |
| ta                |  | Be Co          | 25. Was case referred to medical  |  |                                   |  | 26. Place of Deat                                   | 1  Yes 2<br>th (Check only one        | 2 No 1 ☐ Yes<br>e)                                 | 2)& 110  |
| 2                 | dIng Physician:<br>h.<br>After this certific<br>funeral director,  | To B           | To res at No  | ospital: 1 ☐ Inpatient   |                                   |  | 4 Nursing H   |                                       | nce 6 Other (Spec                                  | cify)  |
| o uc              | IIng P   |                | 27. Manner of Death 1 Natural 5 □ Pending   | 28a. Date of Injury<br>(Month, Day   | Year) 28b. Time of Injury         | Work   | / at<br>:?<br>Yes 2 ∐ No                            | 28d. Describe ho                      | w injury occurred                                  |  |
| Division or Vital | Attending r death. ector: After by the funer   | Certification: | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined                         | 28e. Place of injury building, etc.  | / - At home, farm, st             |  | 163 2 110   | 28f. Location (St.<br>City or Town    | reet and Number or Ru<br>n. State)                 | ral Route Number,                                  |
| Ö                 | oltal or<br>urs afte<br>eral Dir<br>illed in   |                |   |  |                                   | th occurred at the tin                                       | ne date and place                                   |                                       | ause(s) and manner as                              | stated   |
|                   | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   | Medical        | (Check only 2 Medical Examir  | ner: On the basis of e<br>and manner state   | xamination and/or in              | nvestigation, in my o  | pinion, death occu                                  | rred at the time, d                   | ate and place, and due                             | to the cause(s)                                    |
| )                 | or With Thos   | Z              | 29b. Signature and title of certifier   | onding ,   | Physici                           | CAN DS   | 3643  | 2                                     | 9d. Date signed (Month                             | 18208  |
| 1                 | 54)  |                | 30. Name and address of person who co   | 670  | 1 N.                              | Charle,  | 1 st.4  | -202 Be                               | alt more   | 21239  |
|                   | St.<br>Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year) MAY 2 8 200   | 32 degistrar   | s Signature                       | north  |   |                                       |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Physician 3:02 PM May 26, 2008 Lapinsky Margaret Mary /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F Yrs. Pennsylvania 86 November 19, 1921 Director 179-18-0594 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location r 28a-f show notified at 1 X Yes 2 □ No Director Maryland | Montgomery Rockville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number "natural", or items 23a or United States 2012 Gainsboro Road 20851 Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If flem 27 is marked other the any injury or other trained. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: à 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Stevens Michael Schegan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2012 Gainsboro Road, Rockville, Maryland 20851 Faulkner / Daughter Karey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 31°, 1 Burial 2 □ Cremation 3 □ Removal from State 2008 Drums, Pennsylvania Calvary Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. Shirw Vi Bour M01193 300 W. Montgomery Avenue, Rockville, MD 20851 23a. Part1. Enter the diseast, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final VENTRICULAR FIBRILLATION **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner METASTATIC LUNG CANCER Sign nicely list our Jimes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine CHRONIC OBSTRUCTIVE PULMONARY DISEASE certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 WNo Month Day Year 5 Other (specify) 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 2 No 24a. Was an was a... autopsy performed? Ves 2 2 No 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death Check onl one Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier mosao, mo 00057124 5/27/07 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao, M.D., 9715 Medical Center Dr., #201, Rockville, Maryland 20850 \J 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

68760

Records,

or Vital

Division

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician KA1 38 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** SAFTA HARFORD 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours MM 2□F 1939 NORTHI 36 8929 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Completed by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 40 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 🗖 No Specify: 3 ☐ Widowed 4 ☐ Divorced iHW 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) POBEL OMUZR 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 407 FORVEROR KAY 100021 HAST zhoRia Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition SS HAM 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) APELANDERSAMINA 22. Name and Address of Facility A APILANDS 21. Signature of Funeral Service License PRICYLARO DIEST 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sertic Snock **Physician** /Medical Due to (or as a consequence of): Examiner Acute Cholecy stitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown COPD 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Sleep agnea 24a. Was an performe 2 No Vital Hospital or Attending Physician; funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 63420 May, 26, 2008

Registrar
DHMH 17 Rev 1/2001

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nooneyharr

500 Chesapeake Dr Bel Air, MD 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Rigistrar's Signature

Sid Z. Knaral

MAY 2 8 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month Time of Death 1. Decedent's Name (First, Middle, Last) Day  $200\overset{\text{Year}}{8}$ **Physician** 11:55 P™ 24 William R. Martin May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbott 8785 Howeth Road Wittman If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours 1 XM 2 □ F 1936 Maryland 71 Director 216 34 7220 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shovidical Examiner must be notifled at 1 ☐Yes 2 No Director MD Talbott Wittman 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21676 United States 8785 Howeth Road Funeral death Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after it Hygiene. Armed Forces: 1⊠Yes 2 □ No If Yes, Give Year or Dates: unknown 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No δ Specify: 3 Widowed 4 ☐ Divorced White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 US Government Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be L. Irene Howes Howard W. Martin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11895 Route 216 Fulton, MD 20759 Sharon Wilkerson/Niece 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐Removal from State Crest Lawn Mem. Gard. 5-29-2008 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Universing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown been si should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy pertormed' certificate 2₩ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 XNatural 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatu 29d. Date signed (Month, Day, Year) May 27, 2008 of death (Item 2,3a) (Type, Print) nurantos Ye 2 State 8 Registrar

|                                       |  |                | 1 - State of State of Registrar   | Maryland / De                                   | epartment of H<br>Certificate of L                              | lealth and<br>D <i>eath</i>  | Mental Hygi                       | ene 2008                       | 3 17211   |
|---------------------------------------|--|----------------|---|---|---|------------------------------|-----------------------------------|--------------------------------|---|
|                                       | Physici  | ian            | Decedent's Name (First, Middle, Last)   | C TOCHRY  |   |                              | 2. Date of Death<br>Month         | Day Year                       | 3. Time of Death                                |
|                                       | /Medio   |                | JAME  4a. Facility Name (If not institution, give street and number   |   | McDONNEL  4b. City, Town, or                                    |                              | 05 2                              | 4 2008<br>4c. County of Dea    |   |
|                                       | Exami  | iei            | 7984 McNelin Way  | ,   | Seve  |                              | ur                                | Anne A                         |   |
|                                       | Funeral  |                |   | Age (In yrs. last birth                         | Months Dave   | If Under 24 Hrs<br>Hours Min |                                   | 9. Bir<br>Year) Co             | thplace (State or Foreign                       |
|                                       | Director   |                | 219-30-2738   | 75 Yr   | S.  |                              | 06/21/                            | 1932   Ma                      | ryland  |
|                                       | yland<br>now   |                | 10a. State 10b. County  | 10c. City, Town of                              | or Location   |                              |                                   |                                | 10d. Inside City Limits                         |
|                                       | e Mar<br>la-f sh   | Director       | MD   Anne Arundel   | Seve  | ern   |                              |                                   |                                | 1 ☐ Yes 2 ☑ No                                  |
|                                       | ith th   | Dire           | 10e. Street and Number  |   | 10f. Zip Code   |                              | 10                                | g. Citizen of What Co          | ountry?   |
|                                       | eath v   | Funeral        | 7984 McNelin Way  | et Ever in II C                                 | 21144   |                              | 2                                 | U.S.A.                         | <del></del>                                     |
| 0                                     | within 72 hours after death with the Maryland<br>tiene.<br>than "natural", or items 23a or 28a-f show<br>the Medical Evaminer mast to redified at  | Fun            | I I never Marrieu 2 Viarrieu ( I Viarrieu 2   | No Too  | <ol> <li>Was Decedent of Hi<br/>If Yes, specify Cuba</li> </ol> |                              | to Rican, etc.)                   | 14. Race - Ame<br>Black, White |   |
| 2-0036                                | ral",o   | d by           | 3 ☐ Widowed 4 ☐ Divorced If Yes, Give<br>Year or Date   | s: 1955   | 1 □Yes 2 No   | Specify:                     |                                   | Specify: W                     | hite  |
| בַ                                    | thin 72 ho<br>e.<br>an "natu   | Completed      | 15. Decedent's Education (Specify only highest grade completed)   | 1 (0  | ecedent's Usual Occupa<br>Give kind of work done of             | luring most of wo            | rking 1                           | 6b. Kind of Business/          | Industry  |
| 7                                     | withir<br>lene.<br>than  | duc            | Elementary/Secondary (0-12) College (1-4  | or 5+)  | ife. DO NOT use retired,<br>Dwner                               | )                            |                                   | Custom                         |   |
| D                                     | filed<br>Hyg<br>other<br>ent,  | Be C           | 17. Father's Name (First, Middle, Last)   |   | DWITEL  | 18. Mother's Na              | me (First, Middle, Ma             | Manufac<br>aiden Surname)      | turing  |
| yland                                 | 2 should be and Mental Is marked o   | ToB            | James Joseph McDonne  | ell, Sr.  |   | Rosal                        | ie Hoecl                          | kel                            |   |
| Mar                                   | 2 sho  |                | 19a. Informant's Name/Relationship (Type. Print)  | 1   | failing Address (Street a                                       |                              |                                   |                                | , ,   |
| ນ໌<br>ປ                               | 1 and<br>Health<br>em 27<br>ther t   |                | Mary E. McDonnell/Wife  |   | 984 McNeli  | in Way,                      |                                   | MD 211                         |   |
|                                       | permit. Pages 1 and 2 should be Department of Heath and Menta Important: If Item 27 is marked any Injury or other traumatic enone.   |                | 1 🗷 Burial 2 ☐ Cremation 3 ☐ Removal from Sta   | ie  | isposition (Name of<br>crematory or other place                 |                              |                                   | _                              |   |
| baltimore,                            | mit. Partme  |                | 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service Licensee                                       | vet   | cerans Cen<br>22. Name and Addres                               | n 105/<br>s of Facility C    | 79/08   C                         | Crownsvi                       | Home, PA  |
| ŏ                                     | any any  |                | In the  | 1   | 169 Rivi  | era Dr                       | ive. Pas                          | adena. M                       | Home, PA<br>ID 21122                            |
|                                       |  |                | 23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on e       | sed the death. Do not                           | enter the mode of dying   | g, such as cardia            |                                   |                                | Approximate<br>Interval Between                 |
|                                       | Physician  | H i            | Immediate Cause (Final disease or condition   | nosta   | te cancer   |                              |                                   |                                | Onset and Death                                 |
|                                       | /Medical<br>xaminer  |                | resulting in death)  Due to (or   | es a consequence of)                            |   |                              |                                   |                                |   |
|                                       |  | Jer            | Sequentially list conditions, if any, leading to immediate cause. Enter University Queen Cause (Disease or injury | as a consequence of):                           |   |                              |                                   |                                |   |
|                                       | nd All   | Examiner       | triat initiated events  |   |   |                              |                                   |                                |   |
| 00.00                                 | cate be executed physician and the burial-transit  | E              | resulting in death) Last Due to (or   | as a consequence of):                           |   |                              |                                   |                                |   |
|                                       |  | dical          | d   |   |   |                              |                                   |                                |   |
| 5                                     | Attending Prystolan: The law requires that the death certificarding ar death.  ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as  | sician/Me      | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcomes   |   |   |                              |                                   | 23d. Date of del               | iverv   |
|                                       | death  | icia           | in the past 12 months? 1 ☐ Live birt  | n 2□ Fetal death<br>t at time of death          | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)                       |                              |                                   | Month                          | Day Year  |
|                                       | at the   | Phys           | 9 ☐ Unknown 9 ☐ Unknow  |   |   |                              |                                   |                                |   |
| , ה<br>ה                              | signed   | ρ              | Part II. Other significant conditions contributing to death   | i but not resulting in th                       | e underlying cause give   | n in Part I.                 | 23e. Did toba                     | cco use contribute to          | the cause of death?  obably 4   Unknown         |
| 3                                     | w requires to be signed as should be to shou | etec           |   |   |   |                              |                                   |                                |   |
| ֓֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓ | ne law<br>te has<br>age 2 :  | Completed      |   |   |   |                              | 24a. Was an autopsy performe      | prior to death?                | topsy findings available completion of cause of |
| 9                                     | Fnysician: The la  | Be C           | 25. Was case referred to medical  |   |   | 26. Place of Dea             | 1 □Yes 2)<br>ath (Check only one) | No 1 □Yes                      | 2 □No   |
| •                                     | nysic<br>his ce<br>I direc   | 10 E           | examiner? 1 ☐ Yes 2 No Hospital: 1 ☐ Inpa   | atient 2 ER/Outpa                               | Othe  |                              |                                   | ce 6 ☐ Other (Spe              | cify)   |
|                                       | h.<br>After thi<br>funeral   |                | · particion   | njury 28b. Tim<br>Day, Year) Inju               | ry Work?  |                              | 28d. Describe how                 | injury occurred                |   |
|                                       | death<br>ctor<br>y the f   | licat          | 2 Accident investigation 3 Suicide 6 Could not be 28a Place of  | piury - At home, form                           |   | es 2 □No                     | 20f Location (Ct-                 | -4 d No                        | To the Number                                   |
|                                       | all or An  | Certification: | 4 Homicide determined building,   | njury - At home, farm,<br>etc. <i>(Specify)</i> | street, factory, office   |                              | City or Town,                     | et and Number or Ru<br>State)  | rai Houte Number,                               |
|                                       | nospi<br>4 hou<br>Funer<br>tely fil  | Medical        | 29a. Certifier (Check only one)  1 Certifying Physician: To the be 2 Medical Examiner: On the basis and manner    |   |   |                              |                                   |                                |   |
| 4                                     | vithin 2 To the comple   | Me             | 29b. Signature and title of certifier   |   | 29c. License  | number                       | 290                               | I. Date signed (Monti          | n, Day, Year)                                   |
|                                       |  |                | Manhay  | - D   | D3  | 39505                        | $\wedge$                          | ray 27,                        | 2008  |
| ,                                     | 5+1  |                | 30. Name and address of person who completed cause of   | f death (Item 23a) (Typ                         | 29c. License D 3  De, Print)  OS > 1 tal 7                      | m al                         | en Rin                            | nie N                          | 1D 21061  |
|                                       | Stat   | te             | 31. Date filed (Month, Day, Year) 32. Regi  | strar's Signature                               | 1 . 10 .  | , 7                          | . ,                               | 1                              | ,   |
|                                       | Registra   | ar             | MAY 2 8 2008  | w Dr A  | DE SEL  |                              |                                   |                                |   |

State of Maryland / Department of Health and Mental Hygiene 2008

Comparison of Control State Registrar Amend #1,perMD, g880 6/3/08 TT 1. Decedent's Name (First, Middle, Last)

Meach 2. Date of Death Month **Physician** 1:10<sup>a</sup> M May 25, Raffaela Jones Meach 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Health & Rehabilitation Ellicott City Howard If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 080-07-1527 1 🗆 M 2 X F 93 Director April 6,1915 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Exa<u>miner must be notiffled et</u> MD Ellicott City Howard Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9177 Windflower Drive 21042 USA death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ∏ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2**X** No Specify. Specify \$ 3€ Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be fi lealth and Mental H Marco Benedetto Bridgette permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked any Injury or other traumatic ev Lanni ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9177 Windflower Drive, Ellicott City, MD 21042 Donald W. Jones / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 ■ Removal from State St. Peter's Cemetery 05/31/2008 Troy, NY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Charles L. Stevens Funeral Home Inc. 1501 Fast Fort Avenue, Baltimore, MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Cardio vascular Alkero Scleno lic Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9☐Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1□ Yes or Attending Physician; ector, Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes **XX**No 2 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Certification: 5 Pending investigation (Month, Day Year) 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D30641 6 launt May 27 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramesh Sabapath 201-109 fack Ruch Neck BOOD Baltimore Maryland 21721 0 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 2008 MAY 28 Registrar

DHMH 17 Rev 1/2001

**Physician** /Medical Examiner

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important; If item 27 is marked other i any Injury or other traumatic event, the

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

must be n

"natural", or items

Director

Funeral

Completed by

Be

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filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be exequed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

HUZEFA BAHRAIN

31. Date filed (Month, Day, Year)

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| ompletely filled in by the funeral director, page 2 should be detached for use as the burial-tra | Medical Certification: To Be Completed by Physician/Medical Exa |
| <u>=</u>   | 7   |
| ete  | <u>:</u>  |
| ple  | e   |
|  | 2   |

| shock, or heart failure. List only  | one cause on each line.  | . Do not enter the mit                              | ode or dying, such as cardi                              | ac or respiratory arrest,                            |   | Interval Between                                      |
|---|--|---|--|--|---|---|
| Immediate Cause (Final disease or condition resulting in death)   | a. LUN   |   | VCER   |  |   | Onset and Death                                       |
|   | Due to (or as a consequ  | Jence or):  |  |  | 3   |   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | b<br>Due to (or as a consequ   | uence of);  |  |  |   |   |
| that initiated events resulting in death) Last  | c  |   |  |  |   |   |
|   | Due to (or as a consequ  | ience of):  |  |  |   |   |
|   | <u></u> d  |   | *  |  |   |   |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown | Ideath 3 □ Ectopic                                  |  |  | 23d. Date of del<br>Month                       | livery<br>Day Year                                    |
| Part II. Other significant conditions   | contributing to death but not resu   | ulting in the underlying                            | cause given in Part I,                                   | 23e. Did tobaco                                      | o use contribute to                             | the cause of death?                                   |
|   |  |   |  | 1 <b>X</b> Yes                                       | 2  No 3 Pr                                      | obably 4 Unknown                                      |
|   |  |   |  | 24a. Was an<br>autopsy<br>performed<br>1  Yes 2      | prior to death?                                 | utopsy findings available completion of cause of 2 No |
| 25. Was case referred to medical examiner?  |  | 26. Place of Death (Check only one)                 |  |  |   |   |
| 1 □ Yes 2x No   | Hospital: 1 ☐ Inpatient 2 ☐  | ER/Outpatient 3 ☐ D                                 | OA Other: 4 Nursing                                      | Home 5 Residence                                     | 6 □Other (Spe                                   | cify)   |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident Investigatio   | 19114  | 28b. Time of<br>Injury<br>M                         | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No                | 28d. Describe how in                                 | njury occurred                                  |   |
| 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, street, fabuilding, etc. (Specify)   |  |   | ry, office   | 28f. Location (Street<br>City or Town, St            | eet and Number or Rural Route Number,<br>State) |   |
| 29a. Certifier (Check only one)   | hysician: To the best of my know<br>miner: On the basis of examinat<br>and manner stated.      | wledge, death occurred<br>tion and/or investigation | d at the time, date and placen, in my opinion, death occ | ce, and due to the cause<br>curred at the time, date | e(s) and manner as<br>and place, and due        | s stated.<br>e to the cause(s)                        |
| 29b. Signature and title of certifier   |  |   | c. License number  | 29d.   | Date signed (Month, Day, Year)                  |   |
| 1 1/2   |  |   | 10057173   | Ę  | 5/27/0  | 8   |
| 30. Name and address of person who  | completed cause of death (Item   | 23a) (Type, Print)                                  |  |  |   |   |

State

Registrar

Dares

RD, STE # 314, BALTIMORE MO 21737

AIMPLIEDELFHIA OILP

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 200817214 for State Certificate of Death

**Physici** /Media Examin

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ihu Medical Evaminar must be notified at agine.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

|                               | Registrar Certificate of Death   | Reg. No.   |  |  |  |  |  |  |
|-------------------------------|--|--|--|--|--|--|--|--|
| an<br>al                      |  | Day Year   |  |  |  |  |  |  |
| er                            | An Equilibration of the Advantage of Depth   | 4c. County of Peath  |  |  |  |  |  |  |
|                               | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 10-42-9992 10 | rth<br>ay, Year) 9. Birthplace (State or Foreign<br>Country) Mayland   |  |  |  |  |  |  |
| tor                           | 10a. State 10b. County 10c. City, Town or Location   | 10d. Inside City Limits 1 ☐Ves 2 ☐ No  |  |  |  |  |  |  |
| al Direc                      | 10e. Street and Number 10f. Zip Code 2 1218  | 10g. Citizen of What Country?  |  |  |  |  |  |  |
| Completed by Funeral Director | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Nidowed 4 Divorced 11 Never Divorced 12 Never Divorced 12 Never Divorced 13 Never Divorced 14 Never Divorced 15 Never Divorced 15 Never Divorced 15 Never Divorced 15 Never Divorced 15 Never Divorced 15 Never Divorced 16 Never Divorced 16 Never Divorced 16 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 17 Never Divorced 18 Never Divorced 18 Never Divorced 18 Never Divorced 18 Never Divorced 19 Never D | o- 14. Race - American Indian, Black, White, etc.  Specify: BlACK  |  |  |  |  |  |  |
|                               | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or,5+)   |  |  |  |  |  |  |  |
| To Be (                       | 17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)  Mary Louise Ware   |  |  |  |  |  |  |  |
|                               | 1927 Informant's Name/Relationship (Type. Print)  Kosetta Montague - WIRE 350/ Frieby St. Apt B. F.  | Balto. md. 21218   |  |  |  |  |  |  |
|                               | 20a. Method of Disposition  1 Burial 2 Seremation 3 Removal from State 4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Method of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)   | 20c. Location - City or Town, State  Catons viile · 1910-  |  |  |  |  |  |  |
|                               | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility 270 for Cary Proarch Fitt  | Balto, md. 2,229   |  |  |  |  |  |  |
| ysician/Medical Examiner      | 23a. Part   Ent/r the disease, or complications that caused the death. Do not enter the most of dying, such as cardiac or respiratory as the first of the cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):   | Approximate Interval Between Onset and Death 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 23 members 24 members 24 members 25 members 24 members 25 members 24 members 25 members |  |  |  |  |  |  |
|                               | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.  Due to (or as a consequence of):  Due to (or as a consequence of):   |  |  |  |  |  |  |  |
|                               |  | 23d. Date of delivery<br>Month Day Year  |  |  |  |  |  |  |
| ed by Ph                      | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did   | tobacco use contribute to the cause of death?  Yes 2 ANo 3 Probably 4 Unknown  |  |  |  |  |  |  |
| Be Completed by Physici       | 24a. Was auto perf   |  |  |  |  |  |  |  |
| e C                           | 25. Was case referred to medical  26. Place of Death (Check only   |  |  |  |  |  |  |  |
|                               |  | idence 6 Other (Specify)   |  |  |  |  |  |  |
| Medical Certification; To     | 1 Natural 5 Pending investigation   Month, Day, Year)   Injury   Work?   1   Yes 2   No   1   Yes 2   No   2   No   No   No   No   No   N  | (Street and Number or Rural Route Number,<br>wn, State)  |  |  |  |  |  |  |
| dical Ce                      | 29a. Certifier (Check only one)  CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |  |  |  |  |
| Mec                           | 29b. Signature and title of certifier  29c. License number  020396   | 29d. Date signed (Month, Day, Year)  5/27/08   |  |  |  |  |  |  |
|                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Davis Hahn 5601 Loch Raven Blvd #103 P   |  |  |  |  |  |  |  |
| te<br>ar                      | 31. Date filed (Month, Day, Year)  32. Begistrar's Signature   |  |  |  |  |  |  |  |

DHMH 17 Rev 1/2001

Sta 'Registr

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Moore 5:34 PM Max Robert 16 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 🕅 M 2 🗆 F Yrs 574-34-3523 73 June 27, 1934 Director California Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heathh and Mental Hygiene.
nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at MD Director 1√g Yes 2 □ No Baltimore 10e. Street and Numbe 10f. Zip-Code 10g. Citizen of What Country 216 Longwood Road 21210 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. ≥ Specify: white Year or Dates: 156-58 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ systems analyst Social Security Adm other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Glenn Warner Moore Mary Sharp ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Moore/spouse 216 Longwood Road Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 21. Signature Konald Service licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pancreatie Physician cances months /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) Yes 2 □ No 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 □ Probably 4 □ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate 1 ☐ Yes 2 No 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home Hospital: 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA P 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident filled in by the 3 ☐ Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after within 24 hours a 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) S Hayan, MD RES-000 May 16, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagan Robert S. 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 28 2008 Lillia. Registrar

DHMH 17 Rev 1/2001

State Registrar

MAY 28 DHMH 17 Rev 1/2001

Meegan

31. Date filed (Month, Day, Year)

C. Green

2008

MD

32. Mgistrar's Signature

Union Memorial Hospital

Baltimore, MD 21218

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** <sup>Day</sup> 2008 26, Margaret McDonald Ann May 1:40 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Montgomery Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 □ M 2 🛛 F Director 383-32-3978 73 July 13, 1934 Michigan Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location if than "natural", or items 23a or 28a-f show 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11213 Deborah Drive 20854 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No \$ Specify: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n, any injury or other traumatic event, the Medit once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James R. Toppin Beatrice Harwood ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald F. McDonald, Jr./Husband 11213 Deborah Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 31, May Parklawn Memorial Park 2008 Rockville, Maryland 21. Signature of Fure ral Se vice Lip 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 W. Montgomery Ave., Rockville, MD 20850 M01193 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiopulmonary Arrest Minutes disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Coronary Artery Disease Days Sequentially list conditions Examiner If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Hospital or Attending Physician: The law requires that the death certificate be executed Acute Myocardial Infarction Days and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 🗓 No Month Day Year 5 ☐ Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📉 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has 24a. Was an performed? Yes 2⊠No ⊺∏Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed Month Day, Year) D60887 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Flyer 5530 Wisconsin Avenue #750, Chevy Chase, Maryland 20815 Jack L

State Registrar

31. Date filed (Molify Day, Dear)

DHMH 17 Rev 1/2001

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10e per fh 2879 5-28-08 vt. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 24<sup>Day</sup> **Physician** ΜÄΫ 2008 7:45P M MARKS LAWRENCE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BRIGHTON GARDENS - COLUMIBA COLUMBIA HOWARD If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day Year) 1 01/06/1921 Birthplace (State or Foreign Country)
 NV 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday **Funeral** NY 092-30-3973 Director Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director HOWARD WOODSTOCK 10e. Street and Number CIRCLE 10f. Zip Code 10g. Citizen of What Country? 11006 DOXBERRY CIRLCE 21163 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 Divorced "natural", Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) is marked other than Elementary/Secondary (0-12) SELF EMPLOYED WRITER permit. Pages 1 and 2 should be fill Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARKS BEATRICE BODRKY HILLIARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11006 DOXBERRY CIRCLE, WOODSTOCK, MD 21163 JAMES S. MARKS / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🖾 Removal from State WELLWOOD 05/25/2008 4 ☐ Donation 5 ☐ Other (Specify) PINELAWN, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death YEARS Immediate Cause (Final disease or condition resulting in death) Physician CEREBRAL VASCULAR ACCIDENT /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any the Jing to initial dialocause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autopsy his certificate h I director, page performed 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) ASSITED 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P After th funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred LIVING Certification: 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident To the Funeral Director: completely filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D 56531 MAY 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARRY LI, 8600 SNOWDEN RIVER PARKWAY, #301, COLUMBIA, MD 32. Restrar's Signature 31. Date filed (Month, Day, Year) State

Registrar

MAY 28

2008

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Frank Peter Orlando 23, 2008 May 7:30PM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6505 Bonnie Brae Road Eldersburg Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months Hours 1 € M 2 □ F Yrs. 087-34-2213 Director Feb. 22. 1941 NY Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Ital Medical Examination to Lead that at once. 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐Yes 2 ☑ No Carrol1 Eldersburg 10e. Street and Number 10g. Citizen of What Country? 6505 Bonnie Brae Road 21784 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give<sup>X</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 □Yes 2√▼ No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry District of Columbia Elementary/Secondary (0-12) College (1-4or 5+) Associate Director Office of Unemploment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Agostino Orlando Paqualina Bruv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Vera C. Orlando (Spouse) 6505 Bonnie Brae Road Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Springfield Cemetery | 5/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 21. Signature of Funeral Service Licensee Moored P.O. Box 195 Sykesville, MD 21784 Buan 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Anaplastic months resulting in death) /Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit sician and Due to (or as a consequence of): physician at the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 2 No 1 ☐ Yes 2 🗆 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Injury at Work? 28d. Describe how injury occurred 1 Vatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

Johns / Holuns U.
31. Date filed (Morun, Day, Year)
MAY 2 8

29b. Signature and title of certifier

1350 orleans

or treath (Itami2) a) (Type, Print)

and manner stated.

2008

29c. License number

Street SUNE IMIG BALTIMORE, MARYLAND

29d. Date signed (Month, Day, Year)

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 17220 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Date Month 2. Date of Death Powel **Physician** O'S nehra /Medical 4b. City, Town, or Location of Death Randalls tywn 4c. County of Death
BUINMORE Name (If not institution, give street and number) **Examiner** Hospice at Normnest 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Month, Day, **Funeral** 1 □ M 2 Ø F Hours **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X es 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ∐Yes 2 Mo If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any Injury or other traumatic event, Its 90ce. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be ပ 00 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 Cremation 30-08 4 Donation 5 □ Other (Specify) 22. Name and Address of Facility 23a. Part . In et de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, a heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23d. Date of delivery inancy Month Day Year se given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 2 🗌 No 4 🔲 Unknown 1 🗌 Yes 24a. Was an 1 ☐ Yes 26. Place of Death (Check only one) Other:  $_{4\,\square}$  Nursing Home  $_{5\,\square}$  Residence  $_{6}$  Other (Specify) Notput

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

28a-f show ms 23a or 28a-f sho

the Medical Examinat

,o

| an   | disease condition resulting in death)   | a. lung cancer  |
|--|---|---|
| al<br>er   | resulting in death)   | Due to (or, as e consequence of):   |
| iner   | Sequentially list conditions, if any, leading to immediate                                | bDue to (or as a consequence of):   |
| II Exam  | Cause (Disease or injury that initiated events resulting in death) Last                   | cDue to (or as a consequence of):   |
| Physician/Medical Examiner   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 No 9 □ Unknown      | 23c. If yes, outcome of pregnancy  1  |
| Medical Certification: To Be Completed by Physician/Medical Examir | Part II. Other significant conditions of  | ontributing to death but not resulting in the underlying cau                      |
| Be   | 25. Was case referred to medical examiner?  |   |
| 은  | 1 ☐ Yes 2 MNo   | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA                                       |
| ation:   | 27. Manner of Death    Manner of Death   Matural 5   Pending   2   Accident investigation |   |
| Certification:   | 3 Suicide 6 Could not b<br>4 Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, obuilding, etc. (Specify)  |
| <u>a</u>   | 29a, Certifier 1 Certifying Pt  | nysician: To the best of my knowledge, death occurred at                          |
| Medical  |   | niner: On the basis of examination end/or investigation, in<br>and manner stated. |

injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

Location (Street and Number or Rural Route Number, City or Town, State)

the time, date and place, and due to the cause(s) and manner as stated. my opinion, death occurred at the time, date and place, and due to the cause(s) icense number

060680 of person who completed cause of death (Item 23a) (Type, Print)

MICHELWN 7N Main St Ce 1stentown, MD 21136

29d. Date signed (Month, Day, Year)

108

State Registrar 31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien [2] [1] [8] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 4:15 **Physician** May 2001 U /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner imore lizabeth (en Misine 130 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Min. Days Months 1 ☐ M 2 🕶 F Director 6-26-1924 MD 212-20-5831 83 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County al Hygiene. I other than "naturel", or items 23e or 28a-f ehow vent, ite Medical Examinar must be notified at 1 Yes 2 No Director Ellicott City MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21042 10016 Galahad Ct. Completed by Funeral ould be filed within 72 hours after death Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ➡No Specify Specify: 3 ☐ Widowed 4 ☑ Divorced white 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) construction bookkeeper 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Heath and Mental Important: If tem 27 is marked 4 any injury or other traumatic ever 90cs. is marked Lula P. Lough Paul A. Riggleman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5858 Bellanca Drive Elkridge MD 21075 Mr George Parrott / son 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial 5/23/2008 Elkridge MD 5 Other (Specify) Park 22. Name and Address of Facility

Gary L Kaufman Funeral Home 21. Signature of Funeral Service Livensee M01364 7250 Washington Blvd Elkridge MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ement Physician Pars /Medical as a consequence of): Due to (o Examiner - ans arkinsonism Esquentiary liet so utilions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and Due to (or as a consequence of): Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Tes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an this certificate has autopsy performed? nronic 0125 1 Yes 2 No distas Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After or Attending Natural 2 Accident 5 Pending 1 Yes 2 No investigation after death Director: / filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a To the Funeral L 25t Gartifier Certifying Physician: To the best of my knowledge, death occurred at the time, data and plane, and due to the cause(s) and manner as stated Medical Certifying Physician: To the best of my included a country of the completely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ID 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) T'more, Mary land Ming W MMD Senson 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

8 2008

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

ORIGINAL

| bhinav Paul  |                   |  | e of Maryland  |                       |                          |                          |                     |                        |  |                               | 1700   |
|--|-------------------|--|--|-----------------------|--------------------------|--------------------------|---------------------|------------------------|--|-------------------------------|--|
|  |                   | 1- For State<br>Registrar  | 0 01 11101 910110  |                       | tificate c               |                          |                     | morna.                 |  | g. No.                        | 08 1722  |
| Physicia   | ın/               | 1. Decedent's Name (First, Middle,L  |  |                       |                          |                          |                     |                        | Date of Death     Month                | n<br>Day Year                 | 3. Time of Death<br>0330 hrs                           |
| ledical Exami  | ner               | Abhinav N 4a. Facility Name (if not institution,   | I. Paul  |                       |                          | 4b. City. T              | own, or L           | ocation of De          | May 19, 20                             | 4c. County of E               |  |
|  |                   | University Hospital  | groot and manner,  |                       |                          | Baltin                   |                     |                        |  |                               |  |
| Funeral  |                   | 5. Social Security Number 6.   | Sex 7. Ag  | e (In yrs. la         | st birthday)             |                          | er 1 Year           | If Under 24            | 6.0                                    | F                             | B. Birthplace (State or oreign                         |
| Director   |                   | 025-66-8864  | X M 2 F  | 2                     | 22 Yr                    | Month:                   | s Days              | Hours N                | Dec.31                                 | 1,1985                        | Country) MA  |
| á á  |                   | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City.            | Town or Loca             | ation                    |                     |                        |  |                               | 10d. Inside City Limits                                |
| iaryland<br>8a-f show any<br>af once.  | Ļ                 | Maryland Howar   | rd.  |                       | Ellic                    | cott (                   | City                |                        |  |                               | 1 Yes 2 X No   |
| Aarylai<br>28a-f   | Director          | 10e. Street and Number   |  |                       |                          | 10f. Zip                 |                     |                        | 10                                     | g. Citizen of What            | Country?   |
| h the N<br>23a or<br>totifies  |                   | 3203 Halcyon Co  |  |                       |                          |                          |                     | 1043                   |  | U.S.A.                        |  |
| ath wit  | neral             | 11. Marital Status  1 X Never Married 2 Marri  | 12. Was Decedent<br>Armed Forces?  |                       |                          |                          |                     |                        | Specify Yes or No-<br>rto Rican, etc.) | 14. Race - A<br>White, e      | American Indian, Black,<br>P <sup>t</sup> <b>Asian</b> |
| fter de  | / Fun             | 3 Widowed 4 Divorce  | ed If Yes, Give Year   | X No                  | 1                        | Yes 2                    | X No                | specify:               |  |                               | Indian   |
| ours a   | ed by             | 15. Decedent's Education (Specify  | only highest grade con   | pleted)               |                          |                          |                     | on (Give kind          |  | 16b. Kind of Busin            | ess/Industry   |
| 36<br>in 72 h<br>han "r  | ompleted          | Elementary/Secondary (0-12)  | College (1-4 or :  | 5+)                   | _                        | ident                    | ing ino.            | 20 1101 2501           | ourou,                                 | Schoo                         | 1  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica   | Com               | 17. Father's Name (First, Middle, La   | ust)   |                       |                          |                          | 1                   | 8. Mother's Na         | me (First, Middle, N                   | faiden Sumame)                |  |
| be file<br>be file<br>antal H<br>irked   | Be                | Bajinder Paul  |  |                       |                          |                          |                     |                        | ka Smart                               |                               |  |
|  | 은                 | 19a. Informant's Name/Relationship   | (Type, Print) (Father)   |                       |                          |                          |                     |                        | or Rural Route Num                     |                               |  |
| e, MD<br>and 2 sho<br>fealth and<br>item 27 is<br>traumati   |                   | 20a. Method of Disposition   |  |                       | Place of Dispo           | sition (Nan              | ne of cem           |                        | Date                                   | 20c. Location - C             |  |
| nore   |                   | 1 Burial 2 X Cremation   |  |                       | rematory or o            |                          |                     | 5                      | 5-21-2008                              | Catonsv                       | ille, MD   |
| Baltimore,<br>permit. Pages 1 at<br>Department of He.<br>Important: If ite   | 1                 | 4 Ponation 5 Other Spec<br>21. Signature of Funeral Service Liv                                    |  |                       |                          |                          |                     |                        | mes, Inc.                              |                               |  |
|  | _                 | May M. 15  | sunaun   |                       | 55                       | 555 Tv                   | vin F               | nolls                  | Road Col                               | lumbia, M                     |  |
| Physician<br>/Medical  |                   | 23a. Part I. Enter the disease, or co failure. List only one cause on                              | each line.   |                       |                          | the mode o               | or ayıng, s         | uch as cardia          | ic or respiratory arre                 | est, snock, or neart          | Approximate Interval<br>Between Onset and<br>Death     |
| xaminer  |                   | Immediate Cause (Final disease or condition resulting in death)                                    | Due to (or as a conse  |                       |                          |                          |                     |                        |  |                               |  |
| F  | اء                | Sequentially list conditions,  | b  |                       | ١.                       |                          |                     |                        |  |                               |  |
|  | mine              | if any, leading to immediate<br>cause. Enter Underlying Cause<br>(Disease or injury that initiated | c  | equence or            | ).                       |                          |                     |                        |  |                               |  |
| msi ted  | Exa               | events resulting in death) Last  | Due to (or as a conse  | equence of            | ):                       |                          |                     |                        |  |                               |  |
| executed<br>ian and<br>ial - transit   | lical             | UNPENDED   | d AMENDED It   | em 28                 | e per                    | me,g                     | 379,0               | )5/2 <mark>8/</mark> ( | )8dhb                                  |                               |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the built  | Physician/Medical | IF FEMALE:<br>23b. Was decedent pregnant in the  | 23c. If yes, outcor  | ne of pregn           | iancy                    |                          |                     |                        |  | 23d. Date of de               |  |
| certification of the certifica | cian              | past 12 months?  | 1 Live birth 4 Pregnant at   | time of dea           | ath -                    | etal death<br>other (Spe | 3 ∟<br>cifvl        | Ectopic pre            | gnancy                                 | Month                         | Day Year   |
| BO)  | hysi              | 1 Yes 2 No 9 Unkno   | 9OHKHOWH   |                       |                          |                          |                     |                        |  |                               |  |
| ords, P.O. I   | by P              | Part II. Other significant condition   | s contributing to deat   | but not re            | sulting in the           | underlying               | cause gi            | ven in Part I.         | 23e. Did to                            |                               | Ite to the cause of death?  Probably 4 Unknown         |
| ds, l  | Completed         |  |  |                       |                          |                          |                     |                        |  | an   24b. We                  | ere autopsy findings available                         |
| cords,<br>e law requir<br>e has been s   | ם                 |  |  |                       |                          |                          |                     |                        | autop:                                 | med? dea                      | or to completion of cause of ath?                      |
| Vital Recolysician: The law his certificate has director, page 2 sl  |                   | 25. Was case referred to medical   | <del></del>  |                       |                          |                          | 26.Place            | of Death (Che          | 1 Yes :                                | 2 No 1                        | Yes 2 No   |
| Vita<br>hysicia<br>this ce   | To Be             | examiner?<br>1 ✓ Yes 2 No  |  | h-man-mad             | ER/Outpatier             | nt 3 🔲 D                 | OA C                | Other Nu               | rsing Home 5                           | Residence 6                   | Other:   |
| Division of Vital Records, tal or Attending Physician: The law requirers after death.  sl Director: After this certificate has been sited in by the funeral director, page 2 should be   |                   | 27. Manner of Death  1 Natural 5 Pending   | 28a. Date of Inju<br>(Month, Day)<br>May 18, 2008  | Гу<br>ear)            | 28b. Time of<br>1851 hrs | Injury                   |                     | at Work?               | 28d. Describe t<br>Subject shot        | now injury occurred<br>t self |  |
| ivisior or Attend after death Director:  | cati              | 2 Accident Pending   | ,  |                       |                          | eet factory              |                     |                        | 28f Location (S                        | Street and Number             | or Rural Route Number, City                            |
| Divi   | Certification:    | 3 ✓ Suicide 6 Could n 4 Homicide determi   | ot be  | <del>ier (spe</del> c | D:                       | cing l                   |                     |                        | or Town, S                             |                               | _  |
| Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  |                   | 29a. Certifier 1 Certifying Phys   | sician: To the best of m   | y knowledg            | e, death occi            | urred at the             | time, dat           | e and place,           | and due to the caus                    | e(s) and manner a             | s stated.  |
| To the within To the compl   | Medical           |  | ner:On the basis of exa<br>and manner stated.  | mination ar           | nd/or investig           |                          |                     |                        | ed at the time, date                   |                               |  |
|  | 2                 | 29b. Signature and title of certifier  | 11   | 1                     |                          | 290                      | c. License<br>O.C.N |                        |  | May 19, 200                   | (Month, Day,Year)<br>8                                 |
|  |                   | 30. Name and address of person wh  | no completed cause ®   | eath (Item            | 23a)                     |                          |                     |                        |  | ,,                            |  |
| 5  |                   | Zabiullah Ali, M.D. As   | sistant Medical Ex   | aminer                | 111 Pe                   | nn Stree                 | t, Baltii           | more, MD               | 21201                                  |                               |  |
| St<br>Regist   | ate               | 31. Date filed (Month, Day, Year) MAY 2 8 20   | 22. Registra   | r's Signatu           | has                      | B. j                     |                     |                        |  |                               |  |
| - regist   | للتح              | STREETS IN THE STREET  | A CONTRACTOR OF THE PARTY OF TH | A 40                  | AND ADDRESS OF           |                          |                     |                        |  |                               |  |

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygien 2008 1 - State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** 20 PM JOHN WESLEY RUFF, JR na 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore C Under 1 Year If Under 24 Hrs. 5. Social Security Number Jenera Hospital Hu 8. Date of Birth (Month, Day, Year) 9. Birthplac Country 05/13/1928 NORTH Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Sex 1⊠M 2□F Months Days Hours Min. 220-24-1978 80 Director CAROLINA Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1X Yes 2 □ No Funeral Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "natural", or Items 23a or the Madical Exercitor must be a filed within 72 hours after death with 7004 PARK HEIGHT AVE APT K-2 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 le marked other then ury or other treumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY 11 MACHINE OPERATOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 JOHN W. RUFF, SR ESSIE BURRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHERINE POTTS- SISTER 925 S. WELKER RD, SEVERN, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □Cremation 3 □Removal from State permit. Page Depertment o Important: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) ARBUTUS MEMORIAL 15/29/2008 BALTIMORE, 21. Signatura Funeral Service Lice 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ros Immediate Cause (Final **Physician** TATE CANCER disease or condition resulting in death) /Medical Que to (or as a consequence of): Examiner VEUMON Saquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit Box 68760\_ Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ģ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ cete has been sign. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Mannes of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending efter deeth. f Director: Aft d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 60 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sabar M.D. 40 bate filed (Month, Day, Year) Maryland General 32. Régistrar's Signature State MAY 28 Aleton . Registrar

|  |                  | For State   | State of Marylan  | d / Depar         | rtment of H   | lealth and I                              | Mental Hyg                      | giene 20           | 08 17224   |
|--|------------------|---|---|-------------------|---|---|---------------------------------|--------------------|--|
|  |                  | Registrar  1. Decedent's Name (First, Middle, Last)   |   |                   | mouto or i  | Douin                                     | 2. Date of Dea                  | ath                | 3. Time of Death   |
| Physi  |                  | JOHN LACKER   | 77  |                   |   |   | Month                           |                    | Vear 3: 25 AM  |
| /Med<br>Exam   |                  | 4a. Facility Name (If not institution, give s   |   | 1                 | 4b. City, Town, o                                       | r Location of Death                       |                                 | 4c. County of      |  |
|  |                  | 1 20 KAIROSVAD  | DHALKAHA  |                   | BALTINO   | ILS CI                                    | 77                              |                    |  |
| Funera   | al T             | 5. Social Security Number 6. Sex  | M ODE   |                   | If Under 1 Year<br>Months Days                          | If Under 24 Hrs.<br>Hours Min.            | 8. Date of Birtl<br>(Month, Day | v, Year)           | Birthplace (State or Foreign Country)                                |
| Directo  | r                | 219-15-8262   | IM ZUF  | 38 Yrs.           |   |   | 09/04                           | /1969 N            | Maryland   |
| and  |                  | Usual Residence of Decedent  10a. State 10b. County   | 10c. Cit  | y, Town or Loca   | ation   |   |                                 |                    | 10d. Inside City Limits  |
| Marylan<br>f show<br>ied at  | ō                | MD Baltimor   | re B  | altimo            | re  |   |                                 |                    | 1 □ Yes 2 No   |
| the 28a-   | rec              | 10e. Street and Number  |   |                   | 10f. Zip Code   |   |                                 | 10g. Citizen of Wh | nat Country?   |
| h with   | a<br>D           | 2318 Cider Mill   | Road  |                   | 21234   |   |                                 | USA                |  |
| death  | Funeral Director | 11. Marital Status  | 12. Was Decedent Ever in U<br>Armed Forces?               | .S. 13. W         | as Decedent of H  | lispanic Origin? (S<br>an, Mexican, Puert | pecify Yes or No-               | 14. Race           | - American Indian,<br>, White, etc.                                  |
| or ite   |                  | 1 Never Married 2 Married   | 1 ☐ Yes 2 🔀 No<br>If Yes, Give                            |                   | □ Yes 2 <b>X</b> No                                     | Specify:                                  |                                 |                    | White  |
| urai";   | d by             | 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:  | 100 Decede        | ent's Usual Occup                                       |   |                                 |                    |  |
| "nat   | lete             | 15. Decedent's Educ<br>(Specify only highest grade  | cation<br>completed)                                      | (Give k           | ind of work done O NOT use retired                      | ation<br>during most of wor<br>d)         | king                            | 16b. Kind of Bus   | iness/industry   |
| withii iene.   | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5+)  | 1                 | er Wor  |   |                                 | N/A                |  |
| Hyg other ent, 1   | Be C             | 17. Father's Name (First, Middle, Last)   |   | 1                 |   | 18. Mother's Nan                          | ne (First, Middle,              | Maiden Surname     | )  |
| lid be<br>lental<br>rked o   | 10 B             | Joseph A. Raffe   | erty  |                   |   | Jane G                                    | oodhear                         | ·t                 |  |
| should be send by send | -                | 19a. Informant's Name/Relationship (Type  | pe. Print)  | 1                 |   | and Number or Ru                          |                                 | -                  |  |
| To individual to the following after death with the Maryland 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.  Joint 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at   |                  | Jane Rafferty/  |   |                   |   | Mill Ro                                   |                                 | <b>.</b>           | , MD 21234   |
| Pages 1<br>nent of Hi<br>int: If iter  |                  | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R   | emoval from State D11                                     | Place of Dispos   | ition <i>(Name of</i><br>atory or other place<br>Valley | ce)   05 /                                | Date<br>27/08                   |                    | City or Town, State  |
| Pac<br>tmen<br>tant:   |                  | 4 Donation 5 □ Other (Specify)  | Mei   | morial            | <u> Garder</u>  | ns :                                      |                                 | Timoniu            |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown in Injury or other traumatic event, the Medical Examiner must be notified at  | 010              | 21. Signature of Funeral Service License  | Evaus   |                   |   |   |                                 |                    | tion Services 4D 21234   |
|  |                  | 2.7a. P / 1. Enter the disease, or conclusions, ck, or hear failure. List only or   | cations that caused the deat<br>ne cause on each line.    | th. Do not ente   | r the mode of dyir                                      | ng, such as cardiad                       | or respiratory ar               | rest,              | Approximate<br>Interval Between<br>Onset and Death                   |
| Physicia   |                  | Immediate Cause (rinal disease or condition resulting in death)   | INTRACLAL   | JAL &             | LENGLRA   | 234                                       |                                 |                    | Base and Death   |
| /Medica<br>Examine   |                  | resulting in death)   | Due to (or as a conseq                                    | No.               |   |   |                                 |                    |  |
| Examino  |                  | Sequentially list conditions,   | Due to (or as a consequence)                              |                   | TEDTWA  | 4121                                      |                                 |                    |  |
| igt W ig   | li ii            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | 540 10 (01 40 4 0011000                                   | 1401100 017.      |   |   |                                 |                    |  |
| execu<br>n and<br>ial-tra  | Examiner         | resulting in death) Last  | Due to (or as a consec                                    | quence of):       |   |   |                                 |                    |  |
| icate be executed physician and the burial-transit   | dical            |   | l   |                   |   |   |                                 |                    |  |
| rtifical<br>ng ph<br>as th   | Medi             | IF FEMALE.  |   |                   |   |   |                                 |                    |  |
| ith cer<br>tendir  | an/N             | 23b. was decedent pregnant  | 3c. If yes, outcome pf pregnation 1 ☐ Live birth 2 ☐ Feta |                   | Ectopic pregnanc  | v   |                                 |                    | of delivery  |
| e dea  | Physician/Me     | in the past 12 months? 1 ☐ Yes 2 ☐ No   | 4□Pregnant at time of o                                   |                   | Other (specify)   |   |                                 | Mon                | th Day Year  |
| d by t   | Ph               | 9 ☐ Unknown  Part II. Other significant conditions cor  | atributing to death but not res                           | sulting in the un | derlying cause giv                                      | en in Part I                              | 23e Did to                      | phaceo use contril | bute to the cause of death?  |
| The law requires that the death certificate be executed at the has been signed by the attending physician and angle 2 should be detached for use as the burial-transit   | ò                | Taken of organization of  | installing to accumple floor                              | and an area are   | gory ing outdoo giv                                     | on arr arr.                               | 1 🗆 1                           |                    | 3 ☐ Probably 4 ☐ Unknown   |
| been should  | Completed        |   |   |                   |   |   | 240 11/20                       | 24h W              | fore autonou findings qualible                                       |
| ne lav<br>has<br>ge 2 :  | ld m             |   |   |                   |   |   | 24a. Was<br>autop<br>perfo      | osy pr             | fere autopsy findings available rior to completion of cause of eath? |
| n: Ti  |                  | 25. Was case referred to medical  |   |                   |   | OC Place of Day                           |                                 | 1.                 | □Yes 2 No  |
| s certi  | o Be             | examiner?   | lospital: 1 Inpatient 2                                   | ER/Outpatient     | 3□ DOA Oth  | oer.                                      | ath (Check only o               | dence 6 □Othe      | r (Specify)  |
| er this  | 11-              | 27. Manner of Death   | 28a. Date of Injury                                       | 28b. Time of      | 28c. Injui  |   |                                 | now injury occurre |  |
| r: After   | tion             | 1 Natural 5 Pending investigation   | (Month, Day Year)   | Injury            |   | rk?<br> Yes 2∐No                          |                                 |                    |  |
| Afte or degree by the  | ific             | 3 ☐ Suicide 6 ☐ Could not be determined   | 28e. Place of injury - At h<br>building, etc. (Special    | ome, farm, stre   | et, factory, office                                     |   | 28f. Location (S<br>City or Tov |                    | r or Rural Route Number,   |
| To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2   | l Certification: |   | sician: To the best of my kno                             |                   |   | me date and place                         |                                 |                    | nner as stated   |
| e Hos<br>124 hc<br>e Fun<br>letely   | Medical          |   | ner: On the basis of examina<br>and manner stated.        |                   |   |   |                                 |                    |  |
| To th<br>withir<br>To th<br>comp   | Me               | 29b. Signature and title of contifier   |   |                   | 29c. Licens   | se number                                 |                                 | 29d. Date signed   | (Month, Day, Year)   |
| ,  | ,                | Mon   |   |                   | 1 63  | 16016                                     |                                 | May 2              | 3 -200.7   |
| 6  |                  | 30. Name and address of person who co   | empleted cause of death (Iter                             | n 23a) (Type, F   | rint)   |   |                                 |                    |  |
|  |                  | DAVID CHESLER M   | A 275. (  | SLEENS            | 5+ 1  | BREMINDER                                 | · M :                           | 71921              |  |
|  | tate             | 31. Date filed (Month, Day, Year)  MAY 2 8 200  | 3 Registrar's Sign  | The Soul          | Mes !   |   |                                 |                    |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 3. Time of Death Date Month 5 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Jeffren Reitzel 0210 AM 27 08 /Medical 4c. County of Death 4a. Facility Name (# not institution, give street and number) 4b. City, Town, or Location of Death Examiner University of Maryland Medicul Center Baltimore If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday, 8. Date of Birth Country) PA **Funeral** Days 1170671967 1 M 2 □ F 40 171-60-5510 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show must be notified at PA 1XXYes 2 No York York Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 49 W. Princess Street, Apt. 2 17404 United States 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or Items 11. Marital Status Black, White, etc. Examiner I ☐ Yes 2 X No f Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: þ 3 Widowed 4 Divorced Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Inportant: If Item 27 Is marked other than "natun any Injury or other traumatic event, the Medical E onee. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Manufacturing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert L. Reitzel Judy E. Catherson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Heather Reitzel, Wife 49 W. Princess Street, Apt. 2, York, PA 17404 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Evans Eagle Crematory 5/29/08 Leola, Pennsylvania 4 Donation 5 Dother (Specify) 21. Signature of Funer I Service Licensee 22. Name and Address of Facility The Young Funeral Home, Inc. ur 317 East Orange Street, Lancaster, PA 17602 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Scorres /Medical Due to (or as a consequence of) Examiner Soft tissue infution Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to for as a consequence Examine Hospital or Attending Physician: The law requires that the death certificate be executed A pue Due to (or as a consequence of). Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş Chramusputher 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a, Was an autopsy performed Yes 2 No HIO W 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: : After t 1 Natural 5 ☐ Pending investigation 1 TYes 2 TNo death. 2 Accident after death I Director: A d in by the f 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Follow Mujsacion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Amber Pollskin, MD S. Greene 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 11:26 A M Robert Clayton Russell May 26, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3146 Forge Hill Road Street Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1**X** M 2□ F Hours Director 214-30-3957 73 Sept. 18, 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a 3146 Forge Hill Road 21154 USA Funeral death or Items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. e filed within 72 hours after al Hygiene.

other than "natural", or Ite LXYes 2 □ No Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify. Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) land 2121 Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental Health and Ments em 27 Is marked 2 Raymond Earl Russell Ruth C. Sims Maryl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Russell / Wife 3146 Forge Hill Rd., Street, Maryland 21154 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 'Department of H Important: If ite any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gardens 5-29-08 Bel Air, Maryland 4 Donation 5 Other (Specify) 21. Signal re of Funeral Service License 22. Name and Address of Facility
MCCOmas Funeral Home, P.A. 50 West Broadway, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should t 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe After this certificate 2 X No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) and title of certifier 29c. License number 29b. Signature 29d. Date signed (Month, Day, 30. Name and address opperson who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar 2008 MAY 28

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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 is marked other any injury or other traumatic event, sine. Pnysician /Medical Examiner as the burial-transit The law requires that the death certificate be executed attending physician for use as the burial Division of Vital Records, P.O. Box 68760 detached has To the Hospital or Attending Physicien: within 24 hours after death. ∳To the Funerel Director: After this certifica after death.

Director: After this certification by the funeral director, filled in by

Physician/Medical

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Completed

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Certification:

Medical

State

Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28e-1 show

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or Items 23a death v

be filed within 72 hours after de tal Hygiene. d other then "neturel", or Item

Director

Completed

traumatic event, the Medical Examiner must be notified at

1 ☐ Yes 2 🛣 No 27 Manner of Death 1 Natural 2 Accident

investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

BALTIMORE, MD

29b. Signature and title of certifier OK 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Tem 23a) (Type, Print)

3001. S. HANOVERST . SEENIVASAN

31. Date filed (Month, Day, Year) 2 8 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. N 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** :30 A 2008 /Medical 4c. County of Death give street and number) Town, or Location of Death Name If not institute Examiner Birthplace (State or Foreign Country) 6. Sex (In yrs. last birthday, **Funeral** Days Months 1 M 2 □ F Director Usual Residence of Dec Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 des 2 No **Funeral Director** more et and Number 10f. Zip Code 10g. Citizen of What Country? 10e. Stre 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 12. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 1 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Be Completed by 3 ☐ Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health a Derson 20b. Place of Disposition cemetery, crematory 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu of Juneral Service Licensee 21216 23a. Part1. Inter the disease, o complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Pars /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Divi to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown signed k ignificant conditions contr eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ibuting to Be Completed by 2 100 3 ☐ Probably 1 TYes 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s autopsy performed? 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Defection 6 Other (Specify) 2 No Medical Certification: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation Injury within 24 hours arter control to the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) Reath (Item 23a) (Type Name addres person

State Registrar 31. Date filed (Month, Day,

Year)

8 2008

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Registrar's Signature

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the "Modical Examinar in ust be nutified an once. Baltimore, Maryland 21215-0036

> **Physician** /Medical **Examiner**

Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, A completely filled in by the funeral director, page 2 should be detached for Division of Vital Records, after death

> 10+ State Registrar

31. Date filed (Month, Day,

within 24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** 9:30 PM Wilfred E. Rupp 05 24 2008 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 2507 Cider Mill Road Carney Baltimore If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 X M 2 □ F Months Davs Hours 04/05/1917 216-01-9123 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 ☐ No Director MD Baltimore Carney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2507 Cider Mill Road 21234-2509 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∏Yes 2 ☐ N If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 No 1 ☐ Yes 2 No Specify Specify: þ White 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) advertising salesperson 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick F. Rupp Elizabeth Spellerberg ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sophie V. Rupp / Wife 2507 Cider Mill Road; Carney, MD 21234-2509 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 5/28/2008 Catonsville, MD 22. Name and Address of Facility The Johnson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 8521 Loch Raven Blvd., Towson, MD 21286 23 Faul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforr 1 ☐Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1∐ Yes 2∭ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signatu 29d. Date signed (Month, Day, Year) and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 22a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- Registrar amend #12,15,15,16a,17,18&19a&berlincate of Beach 6/09/08 JH Reg. No. 2008 1. Decedent's Name (First, Middle, Last) **Physician** Richard 06 08 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and numb Examiner Regional Prince George's Laure Hospita aurel If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth
Dec 16, 1937 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**∑**M 2□F Months 70 Director 281-34-3558 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director MD Prince George's Laure1 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with 1 USA 20707 7901 Laurel Lake Court Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. nt: If item 27 Is marked other than "natural", or items 23. Race - American Indian Black, White, etc. unk 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Unit Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XNever Married 2 ☐ Married 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Armv Completed unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) unk 4+ unk Retail Clerk unk or other traumatic event, unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Jean Thompson မ William Francis Rodgers, Jr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7300 Van Dusen Road laurel, MD 20707
1550 Hobart Drive Camarillo, CA 93010
20b. Place of Disposition (Name of cemetery, crematory or other place) Laurel REgional Hospital Lynne Nuibe /sister Department of Health an Important: If item 27 Is any Injury or other trac 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\Deliver(Specify) in state S. Warde Director 21. Signaturu a Funeral Service Roma 1 d 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease or committee to the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate wise (Final Cardiac **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Acute Respiratory Failure Examiner organisally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Pulmonary Disease Obstructive The law requires that the death certificate be executed burial-tra Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical the as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 2 ☐ Fetal death 3 □Ectopic pregnancy ned by the atten detached for u in the past 12 months? Month Day Vear 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Failure Renal 1 XYes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? Anemia page 2 s 2□ No 1 ☐ Yes 1□ Yes 2No the Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 1 ☐ Yes Certification: To 28b. Time of 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: Af
d in by the fur 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide n 24 hours aft le Funeral Di pletely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier (JOH/12no D 17638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7350 Van Duxu Rd #340 Louvel HD 20107 Orellano MO 31. Date filed (Month, Day, Year) MAY 2 8 2008 32. Registrar's Signature State Registrar

08-03502 Charles Rector Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 17231

|  |                | - For State<br>egistrar  |   |                             | (  | Certific     | ate of        | Death                       |           |                     |             | Re                          | g. No.       |              |                                     |                              |
|--|----------------|--|---|-----------------------------|--|--------------|---------------|-----------------------------|-----------|---------------------|-------------|-----------------------------|--------------|--------------|-------------------------------------|------------------------------|
| Physiciar  |                | . Decedent's Name (First, Mi                                   |   |                             |  |              |               |                             |           |                     |             | Date of Deat                |              | Year         | 3. Time of                          |                              |
| edical Examin  |                | Charles Rec  | tor   |                             |  |              |               |                             |           |                     | N           | Month<br>Vlay 7, 20         |              |              | 1643                                | nrs                          |
| 1.tu   | 2              | a. Facility Name (if not institu                               | tion, give s  | street and no               | umber)   |              | 4             | b. City, Tow                | n, or Lo  | ocation of          | Death       |                             | l l          | ounty of De  | ath                                 |                              |
|  |                | Western Maryland H   | lealth S  | ystem Br                    | addock C   | ampus        |               | Cumber                      | land      |                     |             |                             |              | gany         |                                     |                              |
| Funeral  |                | 5. Social Security Numberun                                    | k 6. Sex  |                             | 7. Age (In   | yrs. last bi | rthday)       | If Under 1                  |           | If Under            |             | B. Date of Bir              | th(MM/DD/    | YYYY) g. I   | Birthplace (Sta<br>reign            | <sup>te o</sup> unk          |
| Director   |                |  | 1 X N   | 4 2 F                       |  | 76           | Yrs.          | Months                      | Days      | Hours               | Min.        | Tan 31                      | . 193        |              | Country)                            |                              |
|  | Н              | Jsual Residence of Decedent                                    | 1   |                             | L  |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
| any  | _              | 10a. State 10b. Coun   | ty  |                             | 10c.   | City, Tow    | n or Location | on                          |           |                     |             |                             |              |              | 10d. Inside                         | e City Limits                |
| 8.   |                | MD A1  | 1egar   | nv.                         |  | Cum          | ber1a         | and                         |           |                     |             |                             |              |              | 1 Yes                               | 2 No                         |
| Aaryland 28a-f show  | ᅙ              | 10e. Street and Number   | 10841   |                             |  |              |               | 10f. Zip Co                 | nde       |                     |             | 1                           | 0g. Citizen  | of What C    | country?                            |                              |
| Mar r 28s  | Director       | 18601 Roxbur   | v Ros   | ad                          |  |              |               | 215                         |           |                     |             |                             | _            | SA           |                                     |                              |
| th the Maryland 23a or 28a-f sho   |                |  | •   |                             |  |              | 1             |                             |           |                     | 0 ( 0 :     |                             |              |              | nerican Indian,                     | Plank                        |
| th wi  | as I           | 11. Marital Status 1 Never Married 2                           | Married   | 12. Was De<br>Armed F       |  | unk          |               | s Decedent<br>es, specify ( |           |                     |             | ify Yes or No<br>can, etc.) | 14.          | White, etc   |                                     | DIACK,                       |
| or it  | Ξl             |  |   | 1 Yes                       |  | No           |               | Yes 2 X                     | 1         | **                  |             |                             | 0-           |              | white                               |                              |
| afte   | 2              |  |   | f Yes, Give Ye<br>or Dates: |  |              |               |                             |           |                     | ad af war   | k donunk                    |              | · · · · · ·  |                                     | unk                          |
| hour<br>natu<br>Exan   | eted           | 15. Decedent's Education (S                                    |   |                             |  | 16a          | during mo     | ost of working              | g life. I | DO NOT U            | ise retired | )                           | TOD. KING    | or busines   | 33/IIIdd3ii y                       |                              |
| n 72 n 72 isan "   |                | Elementary/Secondary (0-1 unk                                  | ur  | ,                           | 1-4 or 5+)   | ļ            |               |                             |           |                     |             |                             |              |              |                                     |                              |
| withi<br>withi   | EOM D          |  |   |                             |  |              |               | unk                         | 141       | R Mother's          | Name (E     | irst, Middle,               | Maiden Su    | rname)       |                                     | unk                          |
| 215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica   | اق             | 17. Father's Name (First, Mide                                 | ile, Last)  |                             |  |              |               | ulik                        | ·   '     | D.IVIOLITOI S       | , rame (i   | not, madro,                 |              | namo,        |                                     | unk                          |
| 212'<br>212'<br>ould be<br>Mental<br>marke<br>ic event   | ğ l            | 19a. Informant's Name/Relation                                 | nobin /Tra  | oo Brint \                  |  | 14           | 9h Mailing    | Address                     | Street    | and Numi            | her or Rur  | al Route Nur                | mher City (  | or Town S    | itate, Zip Code)                    |                              |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once   | 2              | O.C.M.E.   | и ізпір (ту   | pe, rinit )                 |  | 9.1          | -             |                             | •         |                     |             | nore, l                     |              | 1201         | , <u>-</u> p,                       |                              |
| MD and 2 sho saith and em 27 is raumati  | H              | 20a. Method of Disposition                                     |   |                             |  |              |               | ition (Name                 |           |                     |             | Date                        |              |              | y or Town, Stat                     | e                            |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If tie   |                | 1 Burial 2 Crema   | ion 3   | Remove                      |  |              | atory or oth  |                             |           | ,                   |             |                             |              | Í            |                                     |                              |
| Page<br>nent on or oth   | 1              | 4 Donation 5 X Other   | Specify:  | <i>i</i> n/s                | tate   |              |               |                             | _         |                     |             |                             |              |              |                                     |                              |
| affi<br>mit.<br>partr<br>port<br>jury  |                | 21. Signature of Future Serv<br>Kon 2 Lo                       | ce Licen  | Valez.                      | Direc  | tor          | 22. N<br>S t  | lame and Adate Ar           | dress o   | of Facility<br>mv B | oard        | 655 W                       | . Bal        | timor        | re Stre                             | et                           |
| <b>យ</b> ខ្លួង គឺ  |                | ( man///   | Baltimore, MD 21201   |                             |  |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
| Physician  |                | 23a. Part I. Enter the disease failure. List orly one car      | disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arre |                             |  |              |               |                             |           |                     |             |                             | rest, shock  | or heart     |                                     | mate Interval<br>n Onset and |
| Medical<br><sup>←</sup> xaminer  | 1              | Immediate Cause (Final dise                                    |   |                             | tensive  | Ather        | rosclei       | rotic C                     | ardi      | ovaso               | ular I      | Disease                     |              |              |                                     | Death III                    |
| Adminier   | - 1            | or condition resulting in death                                | ) D   | ue to (or as                | a conseque   | nce of):     |               |                             |           |                     |             |                             |              |              |                                     |                              |
|  | ال             | Sequentially list conditions,                                  | b   |                             |  |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
|  |                | if any, leading to immediate cause. Enter Underlying Cau       | se  | ue to (or as                | a conseque   | nce of):     |               |                             |           |                     |             |                             |              |              |                                     |                              |
|  | 틺              | (Disease or injury that initiate events resulting in death) La |   | ue to (or as                | a conseque   | nce of):     |               |                             |           |                     |             | -                           |              |              |                                     |                              |
| cecuted<br>1 and<br>- transit  | . 1            | events resulting in deathy La                                  | d.  |                             |  |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
| ficate be execute g physician and the burial - tran  | //Medical      | X UNPENDED   |   | AMENDED                     |  |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
| 760, ficate be g physici the buri  | 읽              | IF FEMALE:   |   | 23c If yes                  | , outcome of   | f pregnanc   | ev            |                             |           |                     |             | _                           | 23d. I       | Date of deli | livery                              |                              |
| 876<br>tifica<br>ng pl   | <u>ا</u> ڇ     | 23b. Was decedent pregnant                                     | n the   |                             | birth  |              |               | tal death                   | 3         | Ectopic             | pregnanc    | су                          | м            | onth         | Day                                 | Year                         |
| that the death certifined by the attending detached for use as in  | siciar         | past 12 months?  |   | 4 Preg                      | nant at time   | of death     |               | her (Specif                 | y)        |                     |             |                             |              |              |                                     |                              |
| Bo<br>e deat   | 2              |  | Unknown   |                             | nown   |              |               | _                           |           |                     |             |                             |              |              |                                     |                              |
| P.O. ss that the gened by  |                | Part II. Other significant co                                  | ditions   | contributing                | to death but   | t not result | ting in the ι | underlying c                | ause gi   | iven in Pa          | rt I.       |                             |              |              | te to the cause                     |                              |
| P.C.   | d by           |  |   |                             |  |              |               |                             |           |                     |             | 1 Ye                        | es 2         | 40 3         | Probably 4                          | Unknown                      |
| ords, k<br>v requires<br>s been sig  | 용미             |  |   |                             |  |              |               |                             |           |                     |             | 24a. Was                    |              |              | re autopsy findi<br>r to completion |                              |
| COI<br>law<br>has<br>e 2 st  | 릵              |  |   |                             |  |              |               |                             |           |                     |             | perf                        | ormed?       | deat         | th?                                 |                              |
| tal Rectinn: The certificate ector, page   | Completed      |  |   |                             |  |              |               | 20                          | Dingo     | of Dooth            | (Chook on   |                             | 2 No         |              | Yes                                 | 2 No                         |
| certi  | 8              | 25. Was case referred to med<br>examiner?                      | _   | ospital:                    |  | a [4] 5D     | 10            |                             | 1/        | of Death            |             | Home 5                      | Residence    | - F C        | Other:                              |                              |
| Physi at dir.  | 유              | 1 ✓ Yes 2 No   |   | '                           | Inpatient  |              | b. Time of I  |                             |           | y at Work           |             | 8d. Describe                |              |              | Julier.                             |                              |
| Civision of Vital Records, the law requirements death.  A Director: After this certificate has been side in my the funeral director, page 2 should be  | ij             | 27. Manner of Death  1 X Natural 5 F                           |   | (Mor                        | e of Injury<br>th, Day,Year)   | 201          | b. Time or i  | ·                           | _         | es 2                |             | .ou. Describe               | : How Injury | occurred     |                                     |                              |
| ttend<br>death<br>death<br>stor:   | <u></u>        |  | ending<br>vestigatio  | n                           |  |              |               |                             |           |                     | -           |                             | (6)          |              | - Down Down                         | Number City                  |
| Min or Xi  | إ≝             |  | ould not b  | e                           | ace of Injury  | - At home    | , farm, stre  | et, factory, o              | office be | uilding, et         | c.   2      | or Town,                    |              | Number o     | or Rural Route                      | Number, City                 |
| ours Pits C  | Certification: | 4 Homicide   | etermined   | 100000                      | -  |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
|  |                | 29a. Certifier 1 Certifyin                                     | Physicia  | n: To the b                 | est of my kn   | owledge, o   | death occu    | rred at the t               | me, da    | te and pla          | ace, and d  | lue to the cau              | use(s) and   | manner as    | stated.                             | ,                            |
| lo the complete compl | Medical        | one) 2 Medical   |   | on the basis                | s of examina<br>stated.  | ation and/o  | rinvestiga    |                             |           |                     | curred at   | ine line, dat               |              |              |                                     |                              |
| ->-0   | Ž∫             | 29b. Signature and title of ce                                 | tifier  | -                           | 1  |              |               |                             |           | e number            |             |                             |              |              | (Month, Day, Y                      | ear)                         |
|  |                | alun   | 1,  |                             | Y  | 7            |               |                             | O.C.I     | M.Ē.                |             |                             | May          | 13, 2008     | 3                                   |                              |
|  | ł              | 30. Name and address of per                                    | son who o   | ompleted ca                 | use of death   |              |               |                             |           |                     |             |                             |              |              |                                     |                              |
|  | -              | Zabiullah Ali, M.D.  | Assis   | tant Med                    | ical Exan  | niner        | 111 Per       | nn Street                   | Balti     | more, I             | MD 212      | 01                          |              |              |                                     |                              |
| Sta  | ite            | 31. Date filed (Month Day)                                     | <b>∂</b> 200  | 8 32                        | Registrar's S  | Signature    | Line          | 2000                        |           |                     | 001         | AC.                         |              |              |                                     |                              |
| Regist   | _              |  |   | 4                           | The State of | And a        | No.           | -200                        |           |                     | OCI         | VIE                         |              |              |                                     |                              |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** May 24, 10:18 A M 2008 Yvonne Reznikov /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 10250 Westlake Drive Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) November 12,1932 Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 🗓 F 415-46-5645 75 Tennessee Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2√ No Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20817 10250 Westlake Drive #408 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No White Specify þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Cosmetologist permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygle Important: If Item 27 Is marked other tl any injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russell Donaldson Emma Weaver 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Reznikov / Son 14 Oskaloosa Court, Derwood, Maryland 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition May 29. 1 X Burial 2 ☐ Cremation 3 ☐Removal from State Parklawn Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, Maryland M01193 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-ChevyChase 7557 Wisconsin Ave., Bethesda, Maryland 20814 21. Signature of Fun I al Service Licensee 23a. Part1. Enter the disease/or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tra Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9☐Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Chronic Obstructive Pulmonary Disease 1X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy perform 1∐ Yes Physiclan: 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 X Yes 2 □ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Hospital or Attending 1 X Natural 5 Pending investigation 1 Yes 2 No 2 Accident after death the 6 ☐ Could not be n 24 hours after des ne Funeral Directo pletely filled in by th 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

within 24 ho

To the Fune

completely f h

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year) MAY 28 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D29730

May 27, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** ARABELLA B. RICE 0050AM 23 5 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosedale Baltimore HOSPITAL Center FRANKLIN SQUA € If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number B. Date of Birth (Month, Day, Year 4/24/1914 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday **Funeral** 1 □ M 2 🔀 F 198-14-0625 94 PA Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Directo MD BALTIMORE NOTTINGHAM 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a 21236 8221 BERRYFIELD DR USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. is marked other than "natural", or ite 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify: WHITE 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CASHIER CROCERY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ORVILLE BRONSON DELLA FRISBIE and 2 should 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S NOTTINGHAM, MD RONALD R. SWINGLE-SON 8221 BERRYFIELD DR 21236 Health em 27 i Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State Pages 1 20a. Method of Disposition permit. Pages Department of Important: If It any Injury or o GARDENS OF FAITH 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/28/08 BALTIMORE, MD 21. Signature of Funeral Service Li 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, INC. 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part1. Enter the diseas shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Fixed **Physician** Arterv DISEGSE disease or condition resulting in death) Coronary /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is listed as a control of the control of th Due to (or as a consequence of): Examine sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ LLaTion 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 0624V 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 R/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division or Vital Records, P.O. Box 68760, Phospital or Attending Pl 24 hours after death. Puneral Director: After the

Maryland 21215-0036

Baltimore,

RABCLLa

T

RIC

State

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

and manner stated.

Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY **Physician** CLORINE SMITH 26 2008 3:16a<sup>™</sup> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner HAVEN NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1□ M 2🔀F 97 10/13/1910 Director BALTIMORE, MD <u> 218-18-0905</u> Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1XYes 2 □ No Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3939 PENHURST AVE 21215 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 □ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 □Yes 🛣 No Specify: BLACK þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 5th College (1-4or 5+) UNKNOWN UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ည UNKNOWN UNKNOWN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. FREIDA JONES-GUARDIAN STREET, BALTIMORE, MD 21202 10 N. CALVERT 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ZION CEMETERY 5/31/08 BALTIMORE, MD f Funeral Service Lucer 22. Name and Address of Facility HOWELL FUNERAL HOME AVE, BALTIMORE, MD 4600 LIBERTY HEIGHTS Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2. No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation

law requires that the death certificate be executed signed by the attending physician and signed by the attended for use as the burial-transi P.O. Box 68760, Division of Vital Records, has e 2 s certificate ha or Attending Physician: director, this Certification: To funeral After death. ours after death.

neral Director: A
filled in by the fu

show

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examener - ust be notified at

filed within 72 hours after death with

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r

d be ₁

Baltimore, Maryland 21215-0036

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

To the Hospital o within 24 hours af To the Funeral Di Medical

N Macen MID

6 ☐ Could not be

determined

29c. License number **D** 15503

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMATUN N NA EBIN 501 D JAHIN STreet, Balto, MD 2/2/7

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) MAY 2 8

DO SARA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008

|           |   |                  | 1 - For<br>State<br>Registrar   | State of Maryland  | Certificate of  |  | vientai Hygie<br>Reg.                           |  | 17233  |
|-----------|---|------------------|---|--|---|--|---|--|--|
| ١         | °<br>Physici  | an               | 1. Decedent's Name (First, Middle, Last)  | 1 (2007)   |   | -  | 2. Date of Death<br>Month                       | Day Yeer                                       | 3. Time of Death                                   |
| }         | /Medic  | al               | 4a. Facility Name (If not institution, give   | A SMITH street and number)   | 4b. City, Town, or  | r Location of Death                                    | 05  | 22 2008<br>4c. County of Death                 | 4461   |
|           |   |                  | WOODSIDE  | CENTER   |   | 2 SPRIN  |   | MONTGON  |  |
|           | Funeral<br>Director   |                  | 5. Social Security Number 6. Sex 123-34-255   | 7. Age (In yrs. las  | st birthday) If Under 1 Year Months Days  | If Under 24 Hrs.<br>Hours Min.                         | 8. Date of Birth<br>(Month, Day, Yo             | 9. Birthp<br>Cour<br>H2 Hev                    | lace (State or Foreign<br>try)<br>JOTIC/NY         |
|           | aryland<br>show   | _                | 10a. State 10b. County  |  | Town or Location  | A 17   |   | 1  | 0d. Inside City Limits 1 MYes 2 □ No               |
|           | the Market  | recto            | 10e. Street and Number  |  | timore, 1   | NY   | 10g.  | Citizen of What Cour                           |  |
|           | ath with  | Funeral Director |   | Street, #2   |   | 201  |   | USA  |  |
| 336       | should be filed within 72 hours after death with the Maryland and Mental Hygiene. marked other than "natural", or Itams 23a or 28a-f show imatic event, it a Madical Ext. "It art mast be rediffed at | by Fune          | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | <ul> <li>12. Was Decedent Ever in U.S. Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:</li> </ul>  | 13. Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 No                         | ispanic Origin? (Si<br>an, Mexican, Puerti<br>Specify: | pecify Yes or No-<br>o Rican, etc.)             | 14. Race - Americ<br>Black, White,             |  |
| 215-0036  | "nature   | leted            | 15. Decedent's Edu<br>(Specify only highest grade   | cation<br>completed)   | 16a. Decedent's Usual Occup<br>(Give kind of work done of<br>life. DO NOT use retired | ation<br>during most of wor                            | king 16l  | b. Kind of Business/Inc                        | dustry   |
| 2         | filed within 72<br>Hygiene.<br>other than "na'<br>ent, il a Mudic   | Completed        | Elementary/Secondary (0-12)   | College (1-4or 5+)   | Nursing   |  |   | ealth  |  |
| Maryland  | ould be filed<br>Mental Hygid<br>arked other<br>atic event, I   | To Be (          | 17. Father's Name (First, Middle, Last) Michael Cole Smit   | h  |   |  | ne (First, Middle, Mai<br>Landine La            |  |  |
| Mary      | 2 2 2 2   |                  | 19a. Informant's Name/Relationship (Ty  |  | 19b. Mailing Address (Street 801 Brantford  |  |   |  |  |
|           | es 1 and 3<br>of Health<br>fitam 27<br>r other tr   |                  | Michael J. Smith -  20a. Method of Disposition  1 □ Burial 2 ★ Cremation 3 □ R  | 20b. Pla   | ce of Disposition (Name of netery, crematory or other place                           |  | -   | . Location - City or To                        |  |
| altimore, | t. Pag<br>rtment<br>rtant: I<br>njury o   |                  | ' 4 □ Donation 5 □ Other (Specify)  | Che  | sapeake Cremat  | tory 5/28  | /2008 B   | eltsville,                                     | MD   |
| Ba        | Depa<br>Depa<br>Impo<br>any ii  |                  | 21. Signature of Funeral Service Ucens  | MOC.30   | kapp rune   | ral & Cre  |   |  |  |
|           |   |                  | 23a. Part1. Enter the disease, or complishock, or heart failure. List only or   | cations that caused the death.   | Do not enter the mode of dyin   | ig, such as cardiac                                    | or respiratory arrest                           | , 115-20710                                    | Approximate<br>Interval Between<br>Onset and Death |
| Ĩ         | Physician<br>/Medical   |                  | Immediate Cause (Final disease or condition resulting in death)   | metaSta  Due to (or as a conseque  | tic lung  | Counces  | <u>,</u>  |  |  |
|           | Examiner  | er               | Sequentially list conditions,   | Rt. Panistas Due to (or as a conseque  | 2 Mass  |  |   |  |  |
| y         | cuted<br>ad<br>ransit   | Examine          | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a conseque   | nca ory:  |  |   |  |  |
| 60,       | tificate be executed<br>ig physician and<br>as the burial-transit   |                  | resulting in death) Last  | Due to (or as a conseque   | nce of):  |  |   |  |  |
| 68760,    |   | Aedicai          | 1555445   |  |   |  |   |  |  |
| .O. Box   | The law requires that the death certifics tile has been signed by the attending ptoge 2 should be detached for use as it.   | Physician/N      | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of pregnand<br>1□Live birth 2□Fetal d<br>4□Pregnant at time of dea<br>9□Unknown  | eath 3 Ectopic pregnancy  | ,  |   | 23d. Date of delive<br>Month                   | ry<br>Day Year                                     |
| <u> </u>  | res that the de<br>signed by the a<br>l be detached f   | by Ph            | Part II. Other significant conditions con   | tributing to death but not resulti   | ing in the underlying cause give  | en in Part I.  | 23e. Did tobac                                  | co use contribute to the                       | e cause of death?                                  |
| Records,  | w require<br>been sig<br>should b   |                  | Hypertensia   | <i>∞</i> ,   |   |  | 1 🗆 Yes   | 2□No 3☑Prob                                    | ably 4 Unknown                                     |
|           |   | Completed        | J'hi Zophre   | we.  |   |  | 24a. Was an autopsy performed                   | prior to con<br>death?                         | osy findings available inpletion of cause of       |
| Vital     | sician: Th<br>certificate<br>rector, pag  | o Be             | 25. Was case referred to medical examiner?  | ospital:   | Oth   | 0.0  | th (Check only one)                             |  |  |
| on of     | ing Phys<br>After this<br>uneral di   | $\vdash$         | 1 Yes 2 XNo  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation   | The second secon | 8b. Time of 28c. Injury Work  | y at   | ome 5 ☐ Residenc<br>28d. Describe how           | e 6 Other (Specify injury occurred             | ')   |
| Division  | after death. Diractor: A  | Certification:   | 3 Suicide 6 Could not be determined   | 28e. Place of Injury - At hom building, etc. (Specify)   |   |  | 28f. Location (Stree<br>City or Town, S         | at and Number or Rura<br>State)                | l Route Number,                                    |
|           | To the Hospital or Ati<br>within 24 hours after d<br>To the Funeral Diract<br>completely filled in by   | edicai C         | 29a. Certifier 1 Certifying Physical Control one) 2 Medical Examination   | sician: To the best of my knowler: On the basis of examinatio and manner stated.   | edge, death occurred at the time<br>in and/or investigation, in my o                  | ne, date and place<br>pinion, death occu               | , and due to the caus<br>rred at the time, date | e(s) and manner as si<br>and place, and due to | ated.<br>the cause(s)                              |
|           | To the within To the comp   | Me               | 29b. Signature and title of certifier   | · MA   | 29c. Licens   |  | 29d.  | Date signed (Month,                            | Day, Year)   |
| •         | 1   |                  | 30. Name and address of persols who co  | moleted cause of death (Item 2   |   | 6530   | i l   | 03/22/0  | Š  |
|           | 4   |                  | FARZANA AJMAL   | MD 9101 Z  | MO AVE, SILV  | ER SPRIM   | IG MO   | 20910  |  |
|           | Sta<br>Registr  |                  | 31. Date filed Month, Day, Year 2008  | 22. Registrar's Signatur   | lossel 1  |  |   |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

|                             |  | •                | State Registrar  |   |                        | Cert                              | ificate of  | Death                                |                                 |                                     | Reg. No.                | <b>4008</b>                                  | 1 /                                   | 236                   |
|-----------------------------|--|------------------|--|---|------------------------|-----------------------------------|---|--------------------------------------|---------------------------------|-------------------------------------|-------------------------|--|---------------------------------------|-----------------------|
|                             | Physici  |                  | 1. Decedent's Name (First, Middle, Las<br>Frank M. Stewart,  |   |                        |                                   |   |                                      |                                 | Date of Dea<br>Month                | Day                     | Year   | 3. Time of 5 20                       |                       |
|                             | /Medic<br>Examin   |                  | 4a. Facility Name (If not institution, give  |   |                        |                                   | 4b. City, Town, o   |                                      | of Death                        |                                     | 4c. Co                  | ounty of Death                               | nty                                   |                       |
|                             | Funeral<br>Director  |                  | 5. Social Security Number 207-22-8721  Usual Residence of Decedent   | ex 7. Age (In 7. Age  | n yrs. last bi         | rthday) _<br>Yrs.                 | If Under 1 Year<br>Months Days                              | If Under<br>Hours                    | Min.                            | Date of Birt<br>Month, Da<br>L. 27, | y, Year)                | 9. Birth<br>Cou<br>Penns                     | place (State ontry)<br>Sylvania       | or Foreign            |
|                             | Maryland a-f show  | ctor             | 10a. State 10b. County  Maryland Harford   |   | c. City, Tov<br>Forest |                                   | ation   |                                      |                                 |                                     |                         |  | 10d. Inside Ci<br>1                   |                       |
|                             | th with the<br>23a or 28<br>ust be not   | ral Director     | 10e. Street and Number<br>1600 Belvue Drive  |   |                        |                                   | 10f. Zip Code<br>21050                                      |                                      |                                 |                                     | Unite                   | n of What Cou                                |                                       |                       |
| 7 <i>0</i><br>0036          | be filed within 72 hours after death with the Maryland ntal Hygiene. ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral       | 11. Marital Status 1 □ Never Married 2 □ Married 3\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\  | 12. Was Decedent Ever<br>Armed Forces?<br>1 X Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates:  | r in U.S.              |                                   | /as Decedent of H<br>Yes, specify Cuba<br>☐ Yes 2XNo        | lispanic Or<br>an, Mexica<br>Specify |                                 | Yes or No<br>an, etc.)              |                         | . Race - Amer<br>Black, White<br>pecify: Whi | , etc.                                |                       |
| 1215-                       | "na<br>edic  | Completed        | 15. Decedent's Ed<br>(Specify only highest gra<br>Elementary/Secondary (0-12)  | ucation<br>de completed)<br>College (1-4or 5+)  |                        | (Give k                           | ent's Usual Occup<br>tind of work done<br>O NOT use retired | during mo                            | st of working                   |                                     | 16b. Kind               | of Business/I                                | ndustry                               |                       |
| ) €<br>land 2               | 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Me  | To Be Co         | 17. Father's Name (First, Middle, Last) Frank M. Stewart   |   |                        |                                   |   | 18. Moth                             | ner's Name <i>(Fi</i>           | rst, Middle,                        | Maiden St               | urname)                                      |                                       |                       |
| 05/l8/0fBaltimore, Maryland | permit. Pages 1 and 2 should but Department of Health and Menter Important: If Item 27 is markent any injury or other traumatic evonce.                                  |                  | 19a. Informant's Name/Relationship (<br>Linda Stewart (Dau   | ghter)  | 82                     | 214 M                             | Address (Street   |                                      | timore,                         | Maryla                              | nd 212                  | 36   |                                       |                       |
| OS<br>imore                 | Pages 1<br>ment of He<br>tant: If Iten<br>jury or oth  |                  | 20a. Method of Disposition  1 XBurial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specification)  | Removal from State  | cemet                  | ery, crem<br>LEW M                | ition (Name of<br>natory or other pla<br>emorial Gd         | ns                                   | Date<br>May 27,                 | 2008                                | Fallsto                 |  | land                                  |                       |
| Balt                        | permit. Departn Importa any inju   |                  | 21. Signature of Funeral Service Licer   | ~~_   |                        | 1 8                               | Name and Address<br>Punera<br>Newport Dr                    | ive, F                               | brest Hi                        | 11, Ma                              | ryland                  |  |                                       |                       |
| •                           | Physician<br>/Medical<br>Examiner  | er               | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate | one cause on each line.   | ical<br>onsequence     | of):                              |   | eu H                                 | anit<br>Ileu                    |                                     | nest,                   |  | Approximatinterval Be Onset and 7 day | tween<br>Death<br>YS  |
| 3 <i>0</i><br>68760,        | death certificate be executed a attending physician and d for use as the burial-transit  | Medical Examiner | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | cDue to (or as a co   | onsequence             | of):                              |   |                                      |                                 |                                     |                         |  |                                       |                       |
| 7 983<br>O. Box 6           | eath certif<br>attending<br>for use as   | Physician/Me     | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome pf produced to the second sec | J Fetal dea            |                                   | Ectopic pregnand<br>Other (specify)                         | у                                    |                                 |                                     | 23                      | d. Date of deli<br>Month                     |                                       | Year                  |
| M O                         | quires that<br>n signed b<br>uld be deta   |                  | Part II. Other significant conditions  | contributing to death but n   | not resulting<br>Here  | in the un                         | derlying cause giv  | ven in Parl                          | 11.                             |                                     | tobacco use<br>Yes 2    | e contribute to                              | the cause of obably 4                 |                       |
| ル<br>Al Records             | n; The law red<br>ficate has bee<br>r, page 2 shot   | Completed by     | Severe H   | ervia   | -i tra                 | 6                                 |   |                                      |                                 | 1□ Yes                              | psy<br>ormed?<br>2 1 No | death?                                       | topsy findings<br>completion of       | available<br>cause of |
| Frank                       | /slclar<br>s certif  | To Be            | 25. Was case referred to medical examiner?  1 Yes 22 No  | Hospital:   | 2   ER/0               | Outpatient                        | t 3 DOA Oti   | hor:                                 | ce of Death C<br>Nursing Home   | 100                                 |                         | □Other (Spe                                  | cify)                                 |                       |
| . ~ 6                       |  | Certification: T | 27. Manner of Death  1   | e 290 Place of injuny   | - At home,             | . Time of<br>Injury<br>farm, stre |   | ]Yes 2[                              | □No                             | Location                            | how injury (Street and  | occurred  Number or Re                       | ıral Route Nui                        | mber,                 |
| Jewa4                       | Hospital o<br>4 hours aft<br>Funeral DI<br>ely filled in   |                  | (Check only 2 Medical Exa  | nysician: To the best of r<br>miner: On the basis of ex   | xamination a           | ge, death                         | occurred at the t   | time, date opinion, d                | and place, and<br>eath occurred | d due to the                        | cause(s) a              | and manner as<br>place, and due              | s stated.                             | (s)                   |
| <b>(</b> )                  | o the vithin 2 of the complet  | Medical          | one) 29b. Signature and title of certifier   | and manner state  | a.<br>                 |                                   | 29c. Licen  | se number                            | r                               |                                     | 29d. Date               | signed (Mont                                 | h, Day, Year)                         |                       |
|                             | 700  |                  | hom  | pron  | MI                     | >                                 | Doe   | 53                                   | 568                             |                                     | May                     | 8,20   | 008                                   |                       |
|                             | 241)   |                  |  | ompson T  | 10                     |                                   | Print) So   | c 4                                  | 568<br>per C                    | Las                                 | ylar                    | rd 2   | Drive<br>21014                        | (                     |
|                             | St<br>Regist   | ate<br>rar       | 31. Date filed (MAY 2 8 200  | 8 22. Registrar's   | Signature              | Good                              | the s   |                                      |                                 | _                                   | )                       |  |                                       |                       |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death OS Month Day **Physician** 9:05 AM rie /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ALTI MORE 9. Birthplace (State or Foreign Country)

Mary Jond. 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Hours Months Davs 1 M 2 F 3 212-07-089 Director 3 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits iral", or Items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No MN Director 14 MOR 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2 a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iten any Injury or other traumatic event. Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify: Completed by 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) tomemak 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be enR ၉ 19a. Informant's Nam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place) Kichard MORE MD 21215 H 3altimore, Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 □ Removal from State of 108 4 Donation 5 Dother (Specify) Kosedale, 21. Signature of Fyneral Service are nisee HARFORD 3 mber Cremation Sen Evans Fineral Chape 23a. Part1. Enter the disease, or com, lication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ACCIDENT Erchoravascular disease or condition resulting in death) MENOLUI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 W No 23d. Date of delivery 1 ☐ Live birth 2 ☐ rec. 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Dav Year 5 ☐ Other (specify) 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 | Yes 2 | No 3 | Probably 4 | Donknown Hypertersion 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypercholostodenie page 2 autopsy performe this certificate 2□No 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural 1 TYes 2 □ No 2 ☐ Accident 6 Could not be

Division or Vital Records, P.O. Box 68760, or Attending Physician:

Director: filled in by the Hospital within 24 hours a

Salvic 31. Date filed (Month, Day, Year) State 28 Registrar 2008 DHMH 17 Rev 1/2001

29b. Signature and title of certifier

determined

3 ☐ Suicide

29a. Certifier

Medical

4 ☐ Homicide

(Check only one)

TH ST 100 32. Registrar's Signature

Saluje

Dalicet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DOOLGOSE

21211

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

105

|                            |   |                     | 1 - For<br>State<br>Registrar   | State of Ma  | aryland / Depa<br><i>Ce</i>                   | artment of F<br>rtificate of I                            | lealth and M<br>Death                                     | ental Hygie                                | 2008   | 17238                           |
|----------------------------|---|---------------------|---|--|---|---|---|--|--|---------------------------------|
|                            | Physic  | on                  | 1. Decedent's Name (First, Middle, L.   |  |   |   |   | 2. Date of Death<br>Month                  | Day Year   | 3. Time of Death                |
|                            | Physici<br>/Medi  |                     | JOHN MELVIN SCHE  | MM, SR.  |   |   |   | MAY  | Ž2 2008  | 8:45P M                         |
|                            | Examir  | ner                 | 4a. Facility Name (If not institution, gi   |  |   | 4b. City, Town, or  | Location of Death   |  | 4c. County of Death                                    |                                 |
| and the                    |   |                     | STELLA MARIS HOS  |  |   | TOW   |   |  | BALTIMOR   |                                 |
|                            | Funeral   |                     | ,   | 1 M M 2 D E  | e (In yrs. last birthday)<br>Yrs.             | If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.                            | 8. Date of Birth<br>(Month, Day,           | (ear) 9. Birthpl                                       | lace (State or Foreign<br>try)  |
|                            | Director  | ļ                   | Usual Residence of Decedent   | , ,  | 95 Yrs.                                       |   |   | Sept.26                                    | ,1912   Mar  | yland                           |
|                            | land<br>ow  |                     | 10a. State 10b. County  |  | 10c. City, Town or Lo                         | cation  | ·   |  | 10   | 0d. Inside City Limits          |
|                            | Mary<br>fsh   | ţ                   | Maryland Baltimon   | re   | Balti   | more Cour   | ntv   |  |  | 1 □Yes 2 No                     |
|                            | r 28a   | irec                | 10e. Street and Number  |  |   | 10f. Zip Code   |   | 100  | J. Citizen of What Count                               | try?                            |
|                            | h with  | <u>a</u>            | 8400 Charles Val  | ley Ct. Apt  | 5. D  |   | 21204   |  | USA  |                                 |
| Maryland 21215-0036        | build be filled within 72 hours after death with the Maryland Mental Hygiene.  arked other than "natural", or items 23a or 28a-f show artic event, the Medical Examirar must be rotified at   | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  **M* Widowed 4 ☐ Divorced  | 12. Was Decedent E<br>Armed Forces?                                  | Ever in U.S. 13.                              | Was Decedent of H<br>If Yes, specify Cuba<br>1 □Yes XX No | Ispanic Origin? (Spe<br>an, Mexican, Puerto F<br>Specify: | cify Yes or No-<br>Rican, etc.)            | 14. Race - America<br>Black, White, e<br>Specify: Whit | etc.                            |
| 2-0                        | 72 ho   | Completed           | 15. Decedent's E<br>(Specify only highest gi  | iducation  | 16a. Dece                                     | dent's Usual Occup  | ation   | 16   | b. Kind of Business/Ind                                | lustry                          |
| 21                         | thin 7  | ם                   | Elementary/Secondary (0-12)   | College (1-4or 5-  | +) (Give                                      | DO NOT use retired  | during most of working)                                   | 1  |  |                                 |
| 7                          | ed wi   | ပ္ပြဲ               | 12 yrs.   | 4 yrs.   | Super   | intendent of  |   |  | merican Smelt  | ing & Ref. Co                   |
| pu                         | should be filed within and Mental Hygiene. marked other than imatic event, the Mental than the matic event, the Mental than the matic event, the Mental than the matic event, the Mental than | Be                  | 17. Father's Name (First, Middle, Las   |  |   |   | 18. Mother's Name   |  | iden Surname)  |                                 |
| yla                        | should and Men marke  | 은                   | William C. Schem  |  |   |   | Ruth Swar   |  |  |                                 |
| Mai                        | 12 sho<br>h and<br><b>is me</b><br>raume  | 1                   | 19a. Informant's Name/Relationship  |  | T T   |   |   |  | City or Town, State, Zip                               | - ·                             |
| ď                          | s 1 and 2 should<br>of Health and Mer<br>item 27 is marke<br>other traumatic  |                     | Claudia S. Troy  20a. Method of Disposition   | (Daughter)   |   |   |   |  | vin, Md. 21<br>c. Location - City or Tox               |                                 |
| Baltimore,                 | ages<br>nt of<br>t: If it   |                     | X⊠ Burial 2 ☐ Cremation 3 [   |  | 20b. Place of Dispo<br>cemetery, crer         |   |   |  | ·  |                                 |
| 臣                          | it. Per<br>artme<br>ritant<br>njury   |                     | 4 □ Donation 5 □ Other (Spec  |  |   | Mem. PK.  2. Name and Addres                              | Cemi. 5⊷27  |  | altimore, M  |                                 |
| Ba                         | permit. Pages 1 Department of F Important: If ite any injury or ot  | i, B                | 21. Signature of Funeral Service Lice   | saln   |   |   | uneral Hor  | TIPE .                                     | 401 Belair<br>alto., Md.                               |                                 |
|                            |   |                     | 23a. Part 1. Enter the disease, or con shock, or heart failure. List only   | nplications that caused<br>y one cause on each lin                   | the death. Do not ent<br>e.                   | er the mode of dyin                                       | g, such as cardiac o                                      | r respiratory arres                        | t,   | Approximate<br>Interval Between |
| 1                          | Physician   |                     | Immediate Cause (Final disease or condition   | PNEUMON  | IA  |   |   |  | 1.5  | Onset and Death                 |
| į                          | /Medical<br>Examiner  |                     | resulting in death)   | Due to (or as a  | a consequence of):                            |   |   |  |  |                                 |
|                            | Zxammer   | <u></u>             | Sequentially list conditions,   | b  |   |   |   |  |  |                                 |
|                            | ted<br>nsit   | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Due to (or as a  | a consequence of):                            |   |   |  |  |                                 |
|                            | execu<br>al-trar  | xar                 | that initiated events<br>resulting in death) Last   | C. Due to (or as a   | a consequence of):                            |   |   |  |  |                                 |
| 68760,                     | rtificate be executed<br>ng physician and<br>as the burial-transit  | ä                   |   |  |   |   |   |  |  |                                 |
| 687                        | ificate<br>g phy<br>is the  | edical              |   | ► C  |   |   |   |  |  |                                 |
| O. Box                     | death cer<br>e attendin<br>d for use a  | Physician/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of 1 Live birth 2 Pregnant at 9 Unknown         | 2 ☐ Fetal death 3 ☐                           | Ectopic pregnancy Other (specify)                         | /   |  | 23d. Date of delive<br>Month                           | <b>ry</b><br>Day Year           |
| ď.                         | requires that the<br>been signed by the   | y Pr                | Part II. Other significant conditions   | contributing to death bu   | it not resulting in the ui                    | nderlying cause give                                      | en in Part I.   | 23e. Did tobac                             | cco use contribute to the                              | e cause of death?               |
| ğ                          | w requires t<br>s been signe<br>should be   | Completed by        |   |  |   |   |   | 1 ☐ Yes                                    | 2 No 3 Proba   | ably 4 ሺ Unknown                |
| ပ္တ                        | aw re   | olet                |   |  |   |   |   | 24a. Was an                                | 24b. Were autop  | osy findings available          |
| Ä                          | The law<br>cate has b   | E O                 | · · · · · · · · · · · · · · · · · · ·   |  |   |   |   | autopsy<br>performe                        | <u>d</u> ? death?                                      | npletion of cause of            |
| ta                         |   | Be C                | 25. Was case referred to medical  | -  |   |   | 26. Place of Death  | (Check only one)                           | Mino   I □ Yes   | 2 🗀 NO                          |
| <b>}</b>                   | ys<br>ei: is  | To E                | examiner?<br>1 ☐ Yes 2 🗶 No   | Hospital:<br>1 ☐ Inpatie   | nt 2 ER/Outpatier                             | nt 3 DOA Othe   |   |  | e 6 XOther (Specify                                    | HOSPICE                         |
| 0 0                        | ng Ph<br>fter thi   | Ë                   | 27. Manner of Death 1   Natural 5 □ Pending   | 28a. Date of Injur<br>(Month, Day                                    | y 28b. Time of Injury                         | 28c. Injury<br>Work                                       | at 2  | 8d. Describe how                           |  |                                 |
| sio                        | Attending or death. ector: Afte by the fune   | cati                | 2 ☐ Accident investigation  | ก  |   | M 1□  | Yes 2 □ No  |  |  |                                 |
| Division of Vital Records, | or At<br>after d<br>Direct<br>in by   | Certification:      | 3 ☐ Suicide 6 ☐ Could not be determined   |  | ry - At home, farm, str<br>. <i>(Specify)</i> | eet, factory, office                                      | 2   | 8f. Location (Stree<br>City or Town, S     | et and Number or Rural<br>State)                       | Route Number,                   |
|                            | urs a   |                     | 00a Cartifica ( <b>T</b> T 0a at 1 a  |  |   |   | n   |  |  |                                 |
|                            | To the Hospital or Attending Ph<br>within 24 hours after death.<br>To the Funeral Director: After th<br>completely filled in by the funeral   | Medical             | 29a. Certifier (Check only one)  1 Certifying P 2 Medical Exa   | hysician: To the best o<br>miner: On the basis of<br>and manner-stat | examination and/or in                         | occurred at the tinvestigation, in my o                   | ne, date and place, a<br>pinion, death occurre            | and due to the cau<br>ed at the time, date | se(s) and manner as st<br>and place, and due to        | ated.<br>the cause(s)           |
|                            | To the within To the Somple   | Me                  | 29b. Signature and title of certifier   |  | 1 1   | 29c. License  | number  | 29d  | . Date signed (Month, E                                | Day, Year)                      |
|                            | 7   |                     | * Freda   | e 1  | tolor   | DS  | 2741  |  | M/00 7   | 3 m 2008                        |
|                            | 7   | -                   | 30. Name and address of person who  | completed cause of de  | eath (Item 23a) (Type.                        | Print)  | . (   | )  | 20100  | 3 2008                          |
| 1                          | U   |                     |   | IGHT 2300  | DULANEY VA                                    |   | TTMONTIN  | 1, MD 210                                  | 193  |                                 |
|                            | Sta   |                     | 31. Date filed (Month, Day, Year)   | 32. Registra   | r's Signature                                 | eles?   |   | - , L.L.                                   |  |                                 |
|                            | Registr   | ar                  | MAY 2.8 20  | U.U. Sidistand   | 1   |   |   |  |  |                                 |

8:45 р.ш.

MAY 22, 2008

JOHN SCHEMM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 27 State of Maryland / Department of Health and Mental Hygiene 27 per dr., g8/9,05/28/08dhb Certificate of Death 17239 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Year SCHWARTZ 09:40AM LINDA MAY 2008 20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE MARBOR HOSPITAL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2□F 214-46-1405 Director 61 Jan 7 1947 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Examiner must be notified at Md. 1 PYes 2 No Baltimore Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 3820 Leadenhall Street 21225 Apt. 1 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 8th College (1-4or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mone. Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cyrus Mitchell Minnie Shipley ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Schwartz, husband 3820 Leadenhall St. Apt. 1 Balto. Md. 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Bayview Crematory 5/24/08 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service P.A. 4001 Rítchie Hgwy Balto. Md. 21225 namerous 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ist only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): **Physician** /Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner SEPSIS Due to (or as a consequence of): PULMONART Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy perform 21 No 1□ Yes 2□No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work?

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

items 23a or 28a-f show

, or

"natural"

attending physician and for use as the burial-tran ed by the a certificate has be rector, page 2 s Hospital or Attending Physician: director. funeral after death by filled in

within 24 hours af To the Funeral D completely filled in To the

Registra

Medical

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certified

5 Pending investigation

6 Could not be determined

29c. License number

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

RESOODI

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

MAY, 20,2008

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

STREET, BALTIMORE, MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PANWAR BHUPESH 13001

MD

31. Date filed (Month, Day, Year)

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

MAY 2 8 2008



|                                |   |                  | For<br>State<br>Registrar  |                              | State of M   | larylan                      | -                             | artment d<br><i>rtificate</i>    |                    |                         | lental Hy                       | giene<br>Reg. No. | 200                      | 8 1                            | 7240             |
|--------------------------------|---|------------------|--|------------------------------|--|------------------------------|-------------------------------|----------------------------------|--------------------|-------------------------|---------------------------------|-------------------|--------------------------|--------------------------------|------------------|
|                                | Physicia  | an l             | 1. Decedent's Nam  |                              |  |                              |                               |                                  |                    |                         | 2. Date of De                   | Day               | Year                     | 3. Time                        | of Death         |
|                                | /Medic  | _                | Alice Alv  |                              |  |                              |                               |                                  |                    |                         | 05/22/                          | 2008              |                          | 10:3                           | 6 A <sup>M</sup> |
|                                | Examin  | er               |  | -                            | ve street and number   | )                            |                               |                                  |                    | ation of Death          |                                 | 4c.               | County of Dea            | th                             |                  |
|                                |   | *                | 7466 Furn  |                              |  | (1                           | and to be desired as a second |                                  | Burn               | ie<br>Inder 24 Hrs.     | O Data of Bir                   |                   | nne Aru                  |                                |                  |
| 7.                             | Funeral   |                  | 5. Social Security N   |                              | Sex 7. A<br>1 ☐ M 2 🖾 F                                      | ge ( <i>in yr</i> s. i<br>69 | ast birthday)<br>Yrs.         |                                  |                    | ours Min.               | 8. Date of Bir<br>(Month, Da    | ny, Year)         | 9. Bil                   | thplace (State<br>ountry)      |                  |
|                                | Director  | -                | 217-34-62<br>Usual Residence of  |                              |  | 69                           |                               | L                                |                    |                         | 9/3/19                          | 38                |                          | MD                             |                  |
|                                | land<br>ow  |                  | 10a. State   | 10b. County                  | · · · · · · · · · · · · · · · · · · ·                        | 10c. City                    | , Town or Lo                  | cation                           |                    |                         |                                 |                   |                          | 10d. Inside                    | City Limits      |
|                                | Mary<br>Frsh<br>fied  | ģ                | MD   | Anne Arı                     | ındel  | G1                           | en Bur                        | nie                              |                    |                         |                                 |                   |                          | 1 □Y€                          | es 2 🔀 No        |
|                                | r 28a   | irec             | 10e. Street and Nu   | J                            |  | 010                          | on Dur                        | 10f. Zip Co                      | de                 |                         |                                 | 10g. Citiz        | zen of What C            | ountry?                        |                  |
|                                | h with  | Funeral Director | 7466 Fur   | nace Bra                     | nch Road   |                              |                               | 2106                             | 51                 |                         |                                 | U.S               | S.A.                     |                                |                  |
|                                | death<br>ms 2<br>r mu   | ner              | 11. Marital Status   |                              | 12. Was Decedent   | t Ever in U.                 | S. 13.                        |                                  |                    | nic Origin? (Sp         | ecify Yes or No<br>Rican, etc.) | )-                | 14. Race - Am            |                                |                  |
| Baltimore, Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | ρ                | 1  □ Never Marr<br>3  ⊠ Widowed  | ried 2 Married<br>4 Divorced | 1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates:                | No                           |                               | 1 ☐ Yes 2K                       |                    | exican, Fueno<br>ecify: | nican, etc.)                    |                   | Black, Whi               | white                          | 9                |
| ŏ                              | 2 ho  | ted              | - /Spor  | 15. Decedent's I             | Education  |                              | 16a. Dece                     | dent's Usual C                   | ocupation          | a most of work          | ina                             | 16b. Kir          | nd of Business           | /Industry                      |                  |
| 218                            | thin 7<br>e.<br>an "r<br>Med  | Completed        | Elementary/Seco  |                              | College (1-4or   | 5+)                          |                               | kind of work of<br>DO NOT use r  |                    | y most of work          | ng                              |                   |                          |                                |                  |
| 7                              | er th   | 5                | 8  |                              |  |                              | Foo                           | d Prepa                          |                    |                         |                                 |                   |                          | od Ser                         | vice             |
| nd                             | tal Hy  | 8                | 17. Father's Name  |                              | it)  |                              |                               |                                  | 18.                | Mother's Name           | e (First, Middle                | , Maiden          | Surname)                 |                                |                  |
| <u>ya</u>                      | Meni Meni arked   | စ္               | William  | Doering                      |  |                              | T                             |                                  | I                  | nez (un                 | known)                          |                   |                          |                                |                  |
| ar                             | 2 sho<br>and<br>is m  |                  | 19a. informant's N   |                              |  |                              |                               |                                  |                    |                         | al Route Numb                   |                   |                          |                                |                  |
| 2                              | and<br>ealth<br>m 27  |                  |  |                              | gert, Jr.,   |                              |                               |                                  |                    |                         | Glen                            |                   |                          |                                |                  |
| O.                             | Jes 1<br>of H<br>If itel  |                  | 20a. Method of Disp  |                              | ☐Removal from State  | C                            | emetery, cre                  | osition (Name of matory or other | r place)           |                         | Date                            | 20c. Lo           | cation - City o          | Town, State                    |                  |
| Ë                              | Pag<br>ment<br>ant:<br>ury o  |                  |  | 5 ☐ Other (Spec              |  | Lou                          |                               | rk Cem                           | -                  |                         |                                 |                   | timore,                  |                                |                  |
| Ball                           | permit<br>Depart<br>Import<br>any in  |                  | 21. Signature of Fu  | uneral Service Lic           | ensee  | 1900                         | V .                           | 2. Name and A<br>ervices         |                    |                         | ngleton<br>Ave. SW              |                   |                          |                                |                  |
| 1                              |   |                  | 23a. Part1. Enter t  | the disease, or co           | mplications that cause<br>y one cause on each                | ed the death                 | n. Do not en                  | ter the mode o                   | f dying, su        | ch as cardiac           | or respiratory a                | ırrest,           |                          | Approxim<br>Interval E         | nate<br>Retween  |
|                                | Physician   |                  | Immediate Cause  | (Final                       | , one cause on caon  | woll.                        | ñ e                           | Om.                              | thm                | 10                      |                                 |                   |                          | Onset an                       | d Death          |
|                                | /Medical  |                  | resulting in death)  | 4                            | Due to (or a   | s a consequ                  | uence of):                    | corry                            | 2 2                | 1                       |                                 |                   |                          |                                |                  |
| - 83                           | Examiner  |                  | Cognontially list on   | nditions                     | b  | rete                         | My                            | O caro                           | lial               | mfa                     | retion                          | ?                 |                          |                                |                  |
| 0                              | ₽ #   | iner             | Sequentially list co<br>if any, leading to in<br>cause. Enter Under<br>Cause (Disease or | nmediate<br>erlying          | Due to (or a   |                              | ,                             | c. 1-                            |                    | ~                       |                                 |                   |                          |                                |                  |
| JAK.                           | ecute<br>ind<br>trans   | Examiner         | Cause (Disease or<br>that initiated events<br>resulting in death)                        | S                            | c  | drone                        |                               | arter                            | y                  | Disa                    | ease                            |                   |                          |                                |                  |
| 68760,4                        | ficate be executed<br>y physician and<br>is the burial-transit  | ũ                | resulting in death)  | Last                         | Due to (or as  | s a consequ                  | uence of):                    |                                  |                    |                         |                                 |                   |                          |                                |                  |
| 876                            | ate b   | edical           |  | •                            | d  |                              |                               |                                  |                    |                         |                                 |                   |                          |                                |                  |
| 9<br>×                         |   | Me               | IF FEMALE:   |                              | 000 15   |                              |                               |                                  |                    |                         | -                               |                   |                          |                                |                  |
| Вох                            | leath certif<br>attending<br>I for use as   | Physician/M      | 23b. Was deceden<br>in the past 12   |                              | 23c. If yes, outcom  | 2 Fetal                      | death 3                       | Ectopic pregi                    |                    |                         |                                 | 2                 | 23d. Date of de<br>Month | elivery<br>Day                 | Year             |
|                                | the a   | sic              | 1□Yes 2<br>9□Unknown   | <b>X</b> No ∣                | 4□Pregnant a<br>9□Unknown                                    | at time of de                | eatn 5L                       | Other (speci                     | ry)                |                         |                                 |                   |                          | ,                              |                  |
| P.0                            | that the  | P                |  |                              | contributing to death  | but not resu                 | ılting in the u               | nderlving caus                   | e given in         | Part i.                 | 23e. Did                        | tobacco u         | se contribute            | to the cause o                 | of death?        |
| ds,                            | w requires that the death cer<br>been signed by the attendir<br>should be detached for use  | l by             | Chron  |                              | structure  |                              |                               |                                  |                    | ecko                    | 1 (20)                          | Yes 2[            | □No 3□F                  | robably 4 [                    | ∐Unknown         |
| Ö                              | v requ  | etec             |  |                              |  |                              |                               | 1                                |                    |                         | 240 18/00                       | 0.00              | Odb Mara                 | utopou finding                 | an available     |
| Rec                            | has<br>ge 2   | Completed        |  |                              |  |                              |                               |                                  |                    |                         | 24a. Was<br>auto                |                   | prior to<br>death?       | utopsy finding<br>completion o | f cause of       |
| <u></u>                        | n: The  |                  | 05.1/  |                              |  |                              |                               |                                  |                    |                         | 1□ Yes                          | SKINO             |                          |                                |                  |
| Vit                            | sicial<br>certii<br>recto   | Be               | 25. Was case referexaminer? 1 ☐ Yes 2 🔯  |                              | Hospital:  | i                            | 5D/0:-t#:-                    |                                  | Othor:             |                         | h (Check only                   |                   |                          |                                |                  |
| ō                              | Phy:<br>r this<br>ral di  | ٠ <u>.</u>       | 27. Manner of Deat   |                              | 28a. Date of In  | jury                         | 28b. Time o                   | nt 3 DOA<br>of 28c.              | Injury at<br>Work? | · □ Nursing Ho          | ome 5 Res<br>28d. Describe      |                   |                          | ecify)                         |                  |
| on                             | ding<br>h.<br>: Afte<br>: fune  | tion             | 1√Natural<br>2 ☐ Accident  | 5 ☐ Pending investigation    | (Month, D  | ay Year)                     | Injury                        | м                                | Work?<br>1 ☐ Yes   | 2 □ No                  |                                 |                   |                          |                                |                  |
| Division or Vital Records,     | Attending Physician: The law requires that the death cert crot death.  scroteath.  After this certificate has been signed by the attending by the inneral director, page 2 should be detached for use a   | fica             | 3 ☐ Suicide  | 6 Could not determine        | be 28e. Place of ir  |                              |                               | reet, factory, o                 | ffice              |                         | 28f. Location                   | Street an         | d Number or F            | Rural Route N                  | umber,           |
| Ö                              | al or   | Certification:   | 4 Homicide   |                              | building, e  | etc. (Specify                | "                             |                                  |                    |                         | City or To                      | wn, State         | )                        |                                |                  |
|                                | To the Hospital or Attending Physician: The law within 24 buours after death.  To the Funeral Director-adth. certificate has completely filled in by the funeral director, page 2.  | Medical (        | 29a. Certifier<br>(Check only<br>one)  |                              | Physician: To the bes<br>aminer: On the basis<br>and manners | of examinat                  |                               |                                  |                    |                         |                                 |                   |                          |                                | e(s)             |
|                                | omple   | Me               | 29b. Signature and   | the of certifier             |  |                              |                               | 29c. L                           | icense nun         | mber                    |                                 | 29d. Dat          | te signed (Mor           | th, Day, Year                  | )                |
|                                | F > F 0   |                  | 1 de   | 1                            | XWY  |                              | MD                            | 7                                | 051                | 596                     |                                 | Mai               | 4 22 0                   | 200                            | 8                |
|                                | 1,  |                  | 30. Name and add   | ress of person wh            | completed cause of   | death (Item                  | 23a) (Type.                   |                                  |                    |                         |                                 |                   | 100                      | 000                            |                  |
|                                | 4   |                  | K- Amba<br>31. Date filed (Mon   | alavane                      | cx 7845  |                              | < wood                        | d Roac                           | 10                 | 3 G                     | len Bu                          | rnie              | MD                       | 210                            | 61               |
| 1                              | Sta<br>Registr  |                  | or, bate filed (MOI:   | MΔY 2. 8                     | 1  | 3 Gigiia                     | K                             | Land !                           | F)                 |                         |                                 |                   |                          |                                |                  |

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 5:30 A M Cora Temple Stewart 2008 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan Nursing Center 9. Birthplace *(State or Foreign Country)* Virginia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Sep. 21, 7. Age (In yrs. last birthday) **Funeral** Year) Months 1□м ЖХ F 220-30-4357 Director 94 1913 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumetic event, the Medical Examination until be motified at XX Yes 2 No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 U.S.A. 953 Argonne Dr. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 □Yes X □ No Specify: 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 11. Marital Status Armed Forces?

1 Yes YZY No
If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 Š 3√Widowed 4 Divorced Specify: Year or Dates: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ James Edward Johnson Cora Lee Chives 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2 sment of Health an ant: If item 27 is Baltimore, Maryland 21218 Evelyn Thaniel / Daughter 953 Argonne Dr. Baltimore, 20a. Method of Disposition

XXI Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o injury or 4☐Donation 5☐Other (Specify) 5/31/08 Oak Park, Virginia Oak Grove Cemetery 21. Signature F e ervice Lic ee 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 15 YRS 4theroscherotic Cardiovascular Disease disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the attending physician and ned for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed Parkinsons Direase 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate DIABETES 2 No 2 🗆 No 1 ☐ Yes 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐Pending investigation 1 Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and tife of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 28987 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARL SPERLING RAVEN BALTO. 5601 LOCH BLID 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Montal Hygione

|  |  |                | For<br>State<br>Registrar  | State of Ma  |                                    | epartment o<br>Certificate  |                                    |                               | ental Hyg<br>F                  | giene<br>Reg. No. 2 (                   | 800                         | 17242  |
|--|--|----------------|--|--|------------------------------------|---|------------------------------------|-------------------------------|---------------------------------|---|-----------------------------|--|
|  | Physici  | an             | 1. Decedent's Name (First, Midd  |  |                                    |   |                                    |                               | 2. Date of Dea<br>Month         | Day                                     | Year                        | 3. Time of Death                                   |
| 1  | /Medic   | al             | Herbert P. Stut  |  |                                    | 4h Cit. Ta  | vn, or Location                    |                               | May 24                          | _                                       | nty of Death                | 7:45 A. M  |
| )  | Examin   | er             | 4a. Facility Name (If not institution  Montgomery Host                         |  | 1100                               | ,   | ville                              | i oi Deatri                   |                                 |   | gomer                       |  |
|  | Funeral  | e di i         | 5. Social Security Number  | 6. Sex 7. Age  | e (In yrs. last birt               |   | ear If Unde                        | er 24 Hrs.                    | 8. Date of Birth                |   | 0.5:41                      | 1 (01-1  |
|  | Director   |                | 424-26-3625  | 1 <b>⊠</b> M 2□F   | 78                                 | Yrs. Months L   | ays Hours                          | l l                           | Month, Day                      | , 1929                                  | Alab                        | ama  |
| land   | t ow   |                | Usual Residence of Decedent  10a. State 10b. County                            | /  | 10c. City, Town                    | or Location   |                                    |                               |                                 |   |                             | 10d. Inside City Limits                            |
| Mary   | a-f shi  | tor            | Maryland Montgo  | omery  | Potoma                             | С   |                                    |                               |                                 |   |                             | 1 ☐ Yes 2 No                                       |
| th the   | or 28  | Director       | 10e. Street and Number   |  |                                    | 10f. Zip Co   | ode                                |                               |                                 | 10g. Citizen                            | of What Cou                 | ntry?  |
| ath w  | s 23a<br>nust b  |                | 8507 Victory La  |  |                                    | 208   |                                    |                               |                                 | United                                  |                             |  |
| ter de   | item:  | Funeral        | 11. Marital Status 1 ☐ Never Married 2 ☑ Mar                                   | 12. Was Decedent 8 Armed Forces? rried 1 X Yes 2 1                             |                                    | 13. Was Deceden<br>If Yes, specify                                | t of Hispanic C<br>Cuban, Mexic    | origin? (Spec<br>an, Puerto F | city Yes or No-<br>Rican, etc.) | 14. F                                   | Race - Amer<br>Black, White |  |
| 036<br>urs af  | al", or<br>Exam  | by             | 3 ☐ Widowed 4 ☐ Divorced   | If Yes, Give   |                                    | 1 ☐ Yes 2 🔯   | No Specify                         | y:                            |                                 | Spe                                     | cify: Wh                    | ite  |
| 5-0<br>72 hg   | 'natul<br>dical  | Completed      | 15. Deceder<br>(Specify only highe   | nt's Education<br>est grade completed)   | 16a.                               | Decedent's Usual C<br>(Give kind of work of<br>life. DO NOT use i | occupation                         | ost of workin                 | g                               | 16b. Kind of                            | f Business/I                | ndustry  |
| 121<br>within  | than   | ршо            | Elementary/Secondary (0-12)  | College (1-4or 5   | 5+) As:                            | me bonoruser<br>sociate D   |                                    |                               |                                 | Univ                                    | ersity                      | 7  |
| Ind 21215-0036<br>be filed within 72 hours after death with the Maryland | ital Hygiene.<br>d other than "natural", or items 23a or 28a-f show<br>event, the M-dical Examiner must be notified at | Be Co          | 17. Father's Name (First, Middle   |  |                                    | <u> </u>  |                                    | her's Name                    | (First, Middle,                 |   |                             |  |
| Maryland<br>2 should be f  | i and Mental Hygiei<br>Is marked other tl<br>raumatic event, th  | To E           | Floyd D. Stutts  | 3  |                                    |   | Rub                                | oye Ea                        | rline l                         | Park                                    |                             |  |
| Maryland 21215-0036  | is ma  |                | 19a. Informant's Name/Relation   |  | i                                  | Mailing Address (S  |                                    |                               |                                 |   |                             |  |
| <b>e, 1</b>  | Healtl<br>em 27  |                | Marilyn A. Stut  20a. Method of Disposition                                    | cts / wire   |                                    | 07 Victor Disposition (Name sy, crematory or other                |                                    |                               | mac, Ma                         | ary Lan<br>20c. Locatio                 |                             |  |
| Baltimore,<br>permit. Pages 1 ar   | ent of<br>nt: If it<br>ny or o   |                | 1 ☐ Burial 2 ☑ Cremation<br>4 ☐ Donation 5 ☐ Other (                           |  |                                    | y, crematory or other<br>ry Cremator                              |                                    | May 27                        | 2008 1                          |   | •                           |  |
| alti<br>mit. F   | Department of Health and Menta<br>Important: If item 27 is marked<br>any injury or other traumatic en<br>once.         |                | 21. Signature of Funeral Service   |  | rioricgonic                        | -   |                                    |                               |                                 |   |                             | ille, Inc.   |
| m §  | B E E B  |                | 7.5.   | A  | 100896                             | 300 W. M  | ontgome                            | ery Av                        | e., Ro                          | ckvill                                  | e, MD                       | 20850-2805   |
|  |  |                | 23a. Part1. Enter the disease, of shock, or heart failure. Lis                 | r cormolications that caused<br>t only one cause on each lir                   | I the death. Do n<br>ne.           | ot enter the mode o   | f dying, such a                    | as cardiac or                 | r respiratory ar                | rest,                                   |                             | Approximate<br>Interval Between<br>Onset and Death |
|  | ysician<br>Medical   |                | Immediate Cause (Final disease or condition resulting in death)                | a. Peritoni  |                                    |   |                                    |                               |                                 |   |                             |  |
|  | aminer   |                |  | b End Stap   | a consequence o                    | 1   |                                    |                               |                                 |   |                             |  |
|  |  | ner            | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury |  | a consequence o                    |   |                                    |                               |                                 |   |                             |  |
| Scute Of C   | and<br>-transi   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last        | C. Due to for go   |                                    | .0.   |                                    |                               |                                 |   |                             |  |
| 68760,7<br>tificate be executed  | physician and<br>s the burial-transit  |                | , , , , ,  | Due to (or as  | a consequence o                    | n).   |                                    |                               |                                 |   |                             |  |
| 687<br>tificate  | g phys<br>as the   | edical         |  | d  |                                    |   |                                    |                               |                                 |   |                             |  |
| Box<br>eath cer  | attending p  | Physician/M    | IF FEMALE:<br>23b. Was decedent pregnant                                       | 23c. If yes, outcome   | pf pregnancy<br>2 □ Fetal death    | 3 □Ectopic preg   | nancv                              |                               |                                 |   | Date of deliv               |  |
| .O. E  | the at<br>hed fo   | /sici          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown                        | 4□ Pregnant at<br>9□ Unknown   |                                    | 5 ☐ Other (speci  |                                    |                               |                                 |   | Month                       | Day Year   |
| <u>a</u>   | been signed by the<br>should be detached   |                | Part II. Other significant condit  | ions contributing to death be  | ut not resulting in                | the underlying caus   | e given in Part                    | t I.                          | 23e. Did to                     | bacco use c                             | ontribute to                | the cause of death?                                |
| rds  | n sign<br>ald be   | Completed by   | Acute Renal Fa   | ilure  |                                    |   |                                    |                               | 1 🗆 Y                           | 'es 2 □ No                              | o 3 □ Pro                   | bably 415Unknown                                   |
| Records,<br>he law requires the  | s bee<br>2 shou  | plete          | Urosepsis  |  |                                    |   |                                    |                               | 24a. Was a                      |   | b. Were aut                 | opsy findings available                            |
|  | page 2   | Com            |  |  |                                    |   |                                    |                               | autop<br>perfor<br>1∐ Yes       | rmed?                                   | death?<br>1 ☐ Yes           | ompletion of cause of<br>2□ No                     |
| Vital  | certificate<br>rector, pag   | Be             | 25. Was case referred to medica examiner?                                      | Hoenital:  |                                    |   | Other                              |                               | (Check only o                   |   |                             | Hospice  |
|  | r this a   | To             | 1 Yes 2 No<br>27. Manner of Death  | 28a. Date of Injur   | ry 28b. T                          | ipatient 3 DOA  | Other: 4 1 N<br>Injury at<br>Work? |                               | ne 5 Resid                      |   |                             | (fy)Inpatient                                      |
| DIVISION OF  | ath.<br>r: After<br>e funera   | ation          | 1 X Natural 5 ☐ Pendii<br>2 ☐ Accident invest                                  | ng <i>(Month, Da</i> y<br>igation  | y Year) Ir                         | njury<br>M  | Work?<br>1 ☐ Yes 2 ☐               |                               |                                 | , |                             |  |
| VIS<br>r Atte  | after death. Director: /   | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide detern                                   |  | ury - At home, far<br>c. (Specify) | m, street, factory, o   | ffice                              | 2                             | 8f. Location (S<br>City or Tow  | treet and Nu                            | mber or Ru                  | ral Route Number,                                  |
| Ditalo   | urs aff<br>eral D<br>illed ir  |                | On O office of the Country of  | In Physician To the book   | - f l                              | d#d#  |                                    |                               |                                 |   |                             |  |
| Hos  | 124 hours at<br>le Funeral D<br>letely filled i  | edical         | 29a. Certifier / 1 K Certifyi (Check only one) 2 Medica                        | ing Physician: To the best of<br>I Examiner: On the basis of<br>and manner sta | examination and                    | d/or investigation, in  | my opinion, d                      | and place, a<br>eath occurre  | ed at the time,                 | date and plac                           | manner as<br>ce, and due    | stated.<br>to the cause(s)                         |
| To the   | within 2  To the   complet   | Me             | 29b. Signature and title of certific   |  |                                    | 29c. L  | cense number                       | r                             | 1                               | 29d. Date sig                           | ned (Month                  | , Day, Year)                                       |
|  |  |                | 1 genia  | e Wrolle   | osle in                            | D00   | 64615                              |                               |                                 | May 2                                   | 26, 20                      | 08   |
| N  | pt1  |                | 30. Name and address of person   |  |                                    |   |                                    |                               |                                 |   |                             |  |
| d  |  | to             | Genevieve Anne 31. Date filed (Month, Day, Year                                |  | M.D., 6                            | 001 Munca   | ster Mi                            | ill Ro                        | ad, Roo                         | ckvill                                  | e, MD                       | 20855  |
|  | Sta<br>Registr   |                | MAY 2 8  |  | J. K.                              | Gover?  |                                    |                               |                                 |   |                             |  |

|   |                | 1 - For<br>State<br>Registrar  | State of Ma   | ryland / D          | epartment of F<br>Certificate of I                              | lealth and M<br>Death                              | ental Hygid<br>Reg                                | 2008   | 17243   |
|---|----------------|--|---|---------------------|---|--|---|--|---|
| Physic  |                | 1. Decedent's Name (First, Middle, La<br>RIVA  |   |                     | SHVARTS   |  | 2. Date of Death<br>Month<br>ViAY 24              | Day Year   | 3. Time of Death 9:02P M                                  |
| /Medi<br>Exami  |                | 4a. Facility Name (If not institution, giv   | e street and number)  |                     |   | Location of Death                                  |   | 4c. County of Death                              | 3.02.   |
| d.  |                | 103 FITZ COURT,  |   |                     |   | ERSTOWN  |   | BALTIMO  |   |
| Funeral<br>Director   |                | 213-90-3520  | ex 7. Age   | (In yrs. last birtl | hday) If Under 1 Year<br>Months Days                            | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth<br>(Month, Day, )<br>01/01/      | 1937 9. Birthp<br>Cour                           | MOLDOVA   |
| laryland<br>show  |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City, Town     | or Location   |  |   | 1  | 0d. Inside City Limits                                    |
| Mar)<br>a-f sh  | ctor           | MD BALTI   | 10RE  | REIST               | ERSTOWN   |  |   |  | 1 ☐ Yes 2 No  |
| ith the or 28 se not  | Director       | 10e. Street and Number   |   |                     | 10f. Zip Code   |  | 100   | g. Citizen of What Cour                          | ntry?   |
| eath w  |                | 103 FITZ COURT,  |   |                     |   | 136  |   | USA  |   |
| I e, INIAI y IAIIU ZIZIO-0000 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced                                    | 12. Was Decedent E<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: | ver in o.s.         | 13. Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 2 🔏 No | Ispanic Origin? (Span, Mexican, Puerto<br>Specify: | ecity Yes of No-<br>Rican, etc.)                  | 14. Race - Americ<br>Black, White,<br>Specify: W | etc.<br>HITE  |
| "natu   | letec          | 15. Decedent's Ed<br>(Specify only highest gra   | lucation<br>de completed)   | 16a.                | Decedent's Usual Occup<br>(Give kind of work done of            | during most of work.                               | ing 16  | 6b. Kind of Business/In                          | dustry  |
| within ene.   | Completed      | Elementary/Secondary (0-12)  | College (1-4or 5+   | -)                  | life. DO NOT use retired SEAMSTR                                | ,  |   | CLOTH  | ING   |
| il Hyg<br>other   | Be C           | 17. Father's Name (First, Middle, Last,  |   |                     |   |  | e (First, Middle, Ma                              |  |   |
| lal ylallu Z<br>Should be filed<br>and Mental Hygi<br>is marked other<br>aumatic event,   | To E           | MARK   |   | KORS                | Н   | SILKA  |   | UNKN   | NWC   |
| 2 sho   |                | 19a. Informant's Name/Relationship (   |   |                     | Mailing Address (Street   |  |   |  |   |
| C, IV 1 and Health em 27 ther to  |                | DANIEL SHVARTS  20a. Method of Disposition   | / HUSBAND   | <del></del>         | 3 FITZ COUR Disposition (Name of                                |  |   | Oc. Location - City or To                        | 21136   |
| t. Page:<br>rtment o<br>rtant: If   |                | 1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation, 5 ☐ Other (Specif   | 1)  | cemetery            | v, crematory or other plac<br>AR SINAI                          | 05/26  | 5/2008  | OWINGS MIL                                       | _S, MD  |
| Deparing any ir   |                | & Michael  | Druge   | ~                   |   |  |   | N & BROS.,<br>KESVILLE, I                        | INC.<br>MD 21208  |
|   | 0.1            | 23a. Part 1. Enter the disease, or com<br>shock, or heart failure. List only<br>Immediate Cause (Final | plications that caused to<br>one cause on each line                                     | the death. Do n     | ot enter the mode of dyin                                       | ng, such as cardiac                                | or respiratory arres                              | st,  | Approximate<br>Interval Between<br>Onset and Death        |
| Physician /Medical  |                | disease or condition resulting in death)   | a. Met  | consequence o       |   | at CA  | Well  |  | 1.5 years   |
| Examiner  |                |  | Due to (or as a   | consequence o       | 1).   |  |   |  | •   |
| / Pg #5   | iner           | Sequentially list conditions, if any, leading to introduct cause. Enter Underlying                     | Due to (or se s   | consequence o       | t):   |  |   |  |   |
| be executed sician and burial-transit   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                                | C   | consequence o       | fl·   |  |   |  |   |
| cate be e   | edical E       |  | .d  |                     | ·/·   |  |   |  |   |
| rtifica<br>ng ph  | Medi           | IF FEMALE:   |   |                     |   |  |   |  |   |
| The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | hysician/M     | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No   | 23c. If yes, outcome of 1 Live birth 2 4 Pregnant at 9 Unknown                          | ≥ ☐ Fetal death     | 3 ☐ Ectopic pregnanc<br>5 ☐ Other (specify) _                   | у  |   | 23d. Date of deliv<br>Month                      | ery<br>Day Year   |
| ned by  | by Ph          | Part II. Other significant conditions  | ontributing to death but  | t not resulting in  | the underlying cause give                                       | en in Part I.                                      | 23e. Did toba                                     | acco use contribute to t                         | he cause of death?  |
| v requires been sign should be  |                |  |   |                     |   |  | 1 ☐ Yes   | 2 No 3 Pro                                       | oably 4 🗌 Unknown   |
| The law recate has be page 2 sho  | Completed      |  |   |                     |   |  | 24a. Was an<br>autopsy<br>performe<br>1 ☐ Yes 2 [ | prior to co                                      | ppsy findings available<br>mpletion of cause of<br>2 ☐ No |
| Attending Physician: The refeath.  ector: After this certificate by the funeral director, pag   | Be             | 25. Was case referred to medical examiner?   | Hospital:   |                     | Oth   |  | h (Check only one)                                |  |   |
| Phys<br>rr this<br>rral dir   | 5              | 1 Yes 2 No<br>27. Manner of Death  | 1 ☐ Inpatien  |                     | patient 3 DOA Other   | 4 □ Nursing Ho                                     | me 5 X Residen<br>28d. Describe how               | ce 6 Other (Speci                                | fy)   |
| nding F<br>ith.<br>: After<br>e funer   | tion           | 1 Natural 5 Pending 2 Accident investigation   | (Month, Day,  |                     | jury Worl   | (?¯`<br>Yes 2 □ No                                 | 284. 20001100 1104                                | injury occurred                                  |   |
| al or Attel   | Certification: | 3 Suicide 6 Could not be determined  | 28e. Place of Injur<br>building, etc.   |                     | m, street, factory, office                                      |  | 28f. Location (Stre<br>City or Town,              | et and Number or Run<br>State)                   | al Route Number,  |
| To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: /  | edical (       | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exar                                      | ysician: To the best of<br>niner: On the basis of<br>and manner state                   | examination and     | death occurred at the tird/or investigation, in my o            | me, date and place,<br>pinion, death occur         | and due to the cau<br>red at the time, dat        | use(s) and manner as see and place, and due t    | stated.<br>o the cause(s)                                 |
| To the within 2 To the comple   | M              | 29b. Signature and title of certifier  | W   |                     | 29c. Licenso 0 3  | 3031   |   | Date signed (Month, $5252$                       | Day, Year)  |
| 6   |                | 30. Name and address of person who   | completed cause of de   | ath (Item 23a) (    | Type, Print)  | ss mills.  | m 2   | 5/25/20<br>1117 (Y                               | DUSUF MAN   |
| Sta<br>'Regist  | ate<br>rar     | 31. Date filed (Month, Day, Year)  | 32. Jegistrar   | 's Signature        | Type, Print)<br>340; OWIM                                       |  | <u> </u>  |  | עיוון אייארדי   |
| - 3   |                | MHINGE   | A CONTRACTOR  |                     |   |  |   |  |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21, 5:00 A<sup>M</sup> **JAMES EDWARD** TAYLOR MAY 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S SOUTHERN MARYLAND HOSPITAL CLINTON If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 M 2 □ F Director 50 MARCH 20, 1958 577-86**-**7669 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No Director PRINCE GEORGE'S MD CAPITOL HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Me Itcal Examiner must be r 20743 USA 9407 ACORN PARK STREET Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: þ 3 Widowed 4 Divorced ear or Dates: WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER PRIVATE 10TH Ith and Mental Hygier 27 is marked other the traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JAMES WARREN TAYLOR HATTIE HALE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any Injury or other trauonce. KYMBER TAYLOR / DAUGHTER 502 E. CYPRESS STREET ELIZABETH CITY, NC 27909 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropoligan Crematory 05-27-2008 Alexandria, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Livesee 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD Donald R. Gray 4308 SUITLAND ROAD SUITLAND, MD 20746 Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, x, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ma Lm 160-1 /Medical (or as a consequence of): Examiner ASTRIC CAN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Human Immune deficemeny Discesse The law requires that the death certificate be executed attending physician and for use as the burial-tran IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9<sup>.</sup>□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 | Yes 2 | No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P funeral 28a. Date of Injury 28h Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Day 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

P.O. Box 68760, Division or Vital Records, To the Hospital or Attending after death.

I Director: A:
d in by the fu filled in by within 24 hours a To the Funeral I

State Registrar

Medical

981:00 KIVIN 31. Date filed (Month, Day, Year)

30. Name and addres

4 ☐ Homicide

29a. Certifier

95ton Rocksut β2. Registrar's Signature

and manner stated.

f person who completed cause of death (Item 23a) (Type, Print)

1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death Yea **Physician** 713 A M 4b. City, Town, or Location of Death 2008 Dar 0 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Numb Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1**X**M 2□ F 213-64 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County Items 23a or 28a-f show Examiner must be notified at Baltimore 1 es 2 No Director 10e. Street and Number 10g. Citizen of What Country? *212*23 JUSA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: P Baltimore, Maryland 21215-0036 1□Yes 2▼No Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Meone. Elementary/Secondary (0-12) College (1-4or 5+) aborer d4h ner's Name (First, Middle Be ( wmoson oe. Print) (Sister) of Town, State, Zip Code) nformant's Name/Relationsh 19b. Mailing Ad 20b. Place of Disposition (Name of cemetery, crematory or other 1 ☐ Burial 2 Cremation 3 □Removal from State 5 ☐ Other (Specify) 4 □ Donation 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) **Physician** HOWS ophageal /Medical to (or as a come quence of): Examiner irrhos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed eportiti Due to (or as a consequence of) Division or Vital Records. P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 Probably 4 Dunknown 24a. Was an Were autopsy findings available prior to completion of cause of performe death? 1 ☐ Yes certificate 21 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2D No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Tyes 2 No 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 🗋 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) and addres

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

Man Oson,

State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Day 3:55AM M May 22, 2008 Edward H. Utley /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Suburban Hospital Montgomery Bethesda Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 6 Sex **Funeral** 1 X M 2 □ F Yrs. Director 312-26-9416 78 November 3, 1929 Indiana Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Mudical Expris at must be notified at once. 10h. County 10a State 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Bethesda Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7112 Armat Drive 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 120 Yes 2 □ No If Yes, Give Year or Dates: 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. é Specify: 3 Widowed 4 Divorced 1971 White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) President & Vice Chairman Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Edward Howe Utley Thea Johannson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7112 Armat Drive, Bethesda, Maryland 20817 Mary C. Utley/ Wife 20b. Place of Disposition (Name of Cemetery, cramatory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 27, 2008 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Cemetery Arlington, Virginia 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 23a. Part 1. Enter the disease, of corp. Lations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Year Merkle Cell Tumor /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. It is a sequence of the cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, \$ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2X No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending F after death. I Director: After d in by the funera Division 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a

To the Funeral D

completely filled i Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 22, 2008 D22775 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick G. Barr, M.D. 5454 Wisconsin Avenue, Chevy Chase, Maryland 20815 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

A.m.

dward

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008 1:40 PMM **Physician** May 17, Vargas Ana Maria /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Days Month, Day, Year) 01/30/1962 Hours Months 1 □ M 2 ■ F 46 Ecuador 220-57-3676 Director Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10b. County 10a, State show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1 ☐ Yes 2 🗷 No MD Montgomery Rockville Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Ecuador 20853-12610 Viers Mill Rd. #101 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Ecuador Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) Own Home than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker marked other 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) es 1 and 2 should be fil of Health and Mental H f Item 27 Is marked ott Be Carmen Tupiza Jose Montaquiza ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12610 Viers Mill Rd. #101 Rockville, MD 20853-Hernan P. Vargas/Husband permit. Pages 1 a Department of Hea 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MAY 23 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ō Silver Spring, Maryland Important: It any Injury of Gate of Heaven 2008 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licensee Stole O Xohman 933 Gist Ave. Silver Spring, Maryland 20910-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dire to for an a nonequireone off Examiner the death certificate be executed as the burial-tran and Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4□Pregnant at time of death signed by the at d be detached fo P.O. 1 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an cate has by page 2 s autopsy performed? 1∐ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 2 No 1 Inpatient 1 ☐ Yes Certification: To ne Hospital or Attending Ph n 24 hours after death. ne Funeral Director: After th 28a. Date of Injury 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide filled in by determined 4 Homicide Procertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical within 24 ho

To the Fune

completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065485 20910 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

MAY 2

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DHMH 17 Rev 1/2001

1500 FOREST GLEN RD: SILVER

State of Maryland / Department of Health and Mental Hygiene 20 17248 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Day 2008 Month **Physician** Minnie Louise VanLeeuwen 24, 10:06 A.M May /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Daltimore Gilchrist Hospice Towson 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/25/1922 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1□M 2□F Months Days Hours Min. 216-16-1801 85 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

In proportant: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Mudical Exprantment is the refilled at once. Maryland Baltimore Timonium 1 ☐ Yes 2XINo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States of America 21093 27 Edgemoor Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: Specify: white AN Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State of Maryland Elementary/Secondary (0-12) College (1-4or 5+) Accountant Prison System 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Hollins 2 Minnie Moog 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21220 Hark Roush 512 A Bowleys Quarters Road Baltimore, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 28, May 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Timonium, Maryland 21. Signature Survice License Peacerul Alvernatives Funeral & Cremation Ctr., P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Stroke disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner hype tesing Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (r as a consequence of) certificate be executed burial-transi Due to (or as a consequence of): signed by the attending physician dbe detached for use as the burial Physician/Medical IF FEMALE: 23c. If ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 □No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of eath 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1) Natural 1 ☐ Yes 2 ☐ No Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Change ST TORGEN effects 6791 N 32. Figistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

24, 2008

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. **2008** 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2 2 **Physician** GLADYS ATWAY WILLIAMS 2008 10:46pM MAY /Medical 4c, County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROCK GLEN NURSING HOME BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/7/1908 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 T F 99 Yrs 220-18-4119 VIRGINIA Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It woulded Examinating to notified at X Yes 2 □ No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21229 USA 10N ROCK GLEN RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: BLACK ≥ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEWIFE DOMESTIC 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ALLEN JARVIS NELLIE SUTHERLIN ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MIDLANDTURN, UPPERMARLBORO, MD 20772 ROBERT LACKLEY- NEPHEW 9610 3altimore, 20b. Place of Disposition (Name of GRAFTON BAPTIST) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 9 □ Other (Specify) 5/31/08 CEMETERY MIDDLESEX, VA CHURCH 21. Signature / uneral Service License 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE, BALTIMORE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mete **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit be executed Due to (or as a consequence of): Box 68760 physician Physician/Medical death certificate the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a d be detached f P.O. a 🗆 Hoknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Division of Vital 2 - No 1 Tyes 2 → No 1 ☐ Yes Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 Ho 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 - Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident investigation filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2 47804 MD Monres 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nonew Plane Aberdeen 16 Abendeen 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAY 2 8 2008 Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008

|              |  | •                | For State Registrar  |  | Certificate of   | Death                          | Reg. N  | 2008                                | 17250   |
|--------------|--|------------------|--|--|--|--------------------------------|---|-------------------------------------|---|
| 4.           | Physicia<br>/Medic   |                  | 1. Decedent's Name (First, Middle, Last)  MORRIS   |  | WALL   |                                | 2. Date of Death Manth                          | 5 208                               | 3. Time of Death  |
| )            | Examin   | 400              | 4a. Facility Name (If not institution, give st   | eneral Hos   | Dital Batti  | If Under 24 Hrs.               | 8. Date of Birth<br>(Month, Day, Yes            | 9. Birthple                         | A ace (State or Foreign                                 |
|              | Director   |                  | 077-24-6382 12<br>Usual Residence of Decedent  | M 2 F 78   | Yrs.   | Hours Will.                    | MARCH 05,                                       | 1930 PEN                            | NSYLVANIA   |
|              | the Marylan<br>28a-f show<br>outified at   | ector            | 10b. County  MARYLAND BALTI  10e. Street and Number  | MORE   | Town or Location  RAN  10f. Zip Code   | DALLS                          |   | Citizen of What Count               | 0d. Inside City Limits  1 ☐ Yes 2 ☑ No                  |
|              | s 23a or<br>nust be r  | Funeral Directo  | 3530 RESOUR  | CE DR, APT<br>2. Was Decedent Ever in U.S.   | 326<br>13. Was Decedent of H   | 21/3                           | 3   | 14. Race - America                  |   |
| 5-0036       | ours after de<br>ral", or item<br>Examiner n   | þ                | 11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced  | Armed Forces?  1 Ayes 2 No If Yes, Give Year or Dates:   | If Yes, specify Cuba<br>1 ☐ Yes 2 🗷 No   | an, Mexican, Puerto            | Rican, etc.)                                    | Black, White, e                     |   |
| 21215-0      | be filed within 72 hours after death with the Maryland ital Hygiene. In a constant, or items 23a or 28a-f show event, the Medical Examiner must be notified at | Completed        | 15. Decedent's Educ<br>(Specify only highest grade   | ation<br>completed)<br>College (1-4or 5+)  | 16a. Decedent's Usual Occup<br>(Give kind of work done<br>life. DO NOT use retired<br>TR-ULK         | during most of work<br>DRIVE   | ing<br>R A,                                     | Kind of Business/Ind                | FREIGHT   |
| and          | be d d   | To Be C          | 17. Father's Name (First, Middle, Last)  | UNKNOWN  | , , , , , ,  | 18. Mother's Nam               | e (First, Middle, Maid                          | len Surname) (MN                    | -UNKNOWN)   |
| timore, Mary | t and 2 sh<br>Health and<br>tem 27 is m  |                  | 19a. Informant's Name/Relationship (Typ)  A SHAWW 20a. Method of Disposition  1 Burial 2 A Cremation 3 Be  | DAUGHTER 20b. Pla  | 19b. Mailing Address (Street  50 35 65  ce of Disposition (Name of netery, crematory or other plant) | LIEAV                          | E, BALT   | TIMORE, M<br>Location - City or Tor | 10 21207<br>wn, State                                   |
| Baltin       | permit. Pages<br>Department of<br>Important: If i<br>any Injury or once.   |                  | 4 Donation 5 Other (Specify)  21. Sonature Funeral Service License   | e & Kon  | 22. Name end Addre   | ss of cility                   | BROWN AVE.                                      | PALTIMORI<br>JR. FUNI<br>BALTO. M.  | ERAL HOME<br>0 21217                                    |
|              | Physician<br>/Medical<br>Examiner  | er               | 23a. Print. Enter the disease, or complic ock, or head failure. List only on Immeriate Cause (Final sease or condition dulting in death)  Sequentially list conditions, if any, leading to immediate | Due to (or as a conseque   | nahuts ti  | ng, such es cardiac<br>Man Ce. | or respiratory arrest,                          |                                     | Approximate<br>Interval Between<br>Onset and Death      |
| 68760,       | rtificate be executed ng physician and as the burial-transit   | Medical Examiner | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.  | Due to (or as a conseque   | once of):  |                                |   |                                     | J.  |
| P.O. Box 6   | The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as it  | Physician/Mec    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | 3c. If yes, outcome pf pregnand<br>1 □ Live birth 2 □ Fetal of<br>4 □ Pregnant et time of dea<br>9 □ Unknown | death 3 Ectopic pregnance  | у                              |   | 23d. Date of delive<br>Month        | ory<br>Day Year   |
|              | uires that<br>signed by  | þ                | Part II. Other significant conditions con  | tributing to death but not result  | ing in the underlying cause give   | en in Part I.                  | 23e. Did tobacc                                 | co use contribute to the            |   |
| Il Records,  | . The law requir<br>cate has been si<br>page 2 should I  | Completed        |  |  |  |                                | 24a. Was an eutopsy performed                   | prior to cor death?                 | psy findings available<br>npletion of cause of<br>2  No |
| r Vital      | Physician:<br>r this certifica<br>ral director, p  | To Be            | T Tes 2 100  |  | TVOdipatient OLI BOA   | ner: 4 ☐ Nursing H             | th <i>(Check only one)</i><br>ome 5 ☐ Residence | e 6 □Other (Specif                  | Y)  |
| Division or  | Ilng<br>Afte<br>fune   | Certification:   | 27. Mann of Death  1 ✓ Natural 5 ☐ Pending  2 ☐ Accident investigation  3 ☐ Suicide 6 ☐ Could not be   | (Month, Day Year)  |  | ry at<br>rk?<br> Yes 2 □ No    | 28d. Describe how in                            |                                     |   |
| <u>&gt;</u>  | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the   |                  | 4 ☐ Homicide determined  | building, etc. (Specify)   |  | in a data and place            | City or Town, Si                                |                                     |   |
|              | the Hosp<br>hin 24 hor<br>the Fund<br>mpletely f   | Medical          | (Check only 2 Medicel Examir one)  | iclan: To the best of my know<br>her: On the basis of examination<br>and manner stated                       |  | opinion, death occu            | rred at the time, date                          |                                     | the cause(s)  |
|              | P N N N  | _                | 29b. Signature and title of certifier  | 1  | 895  | 572                            | 230.  | 05/25/                              |   |
| C            | 2+1  |                  |  | mpleted cause of death (Item 2)  Yarde M. O.  32 Registrer's Signatu   | C/o Maryia   | nd Gene                        | eral Hosp                                       | ital                                |   |
|              | Sta  | ite              | 31. Date filed (Month, Day, Year)  | negistrer's orgination   | Some R. 2  |                                | •   |                                     |   |

DHMH 17 Rev 1/2001

|                     |  |                | For State Registrar  | State of Ma  | ryland / Depi                        | rtificate of  | Death  |                                      | Reg. No.   | 2008                        | 17251  |
|---------------------|--|----------------|--|--|--------------------------------------|---|--|--------------------------------------|------------|-----------------------------|--|
| F                   | Physici<br>/Medic  |                | Decedent's Name (First, Middle, Last,     Galen Wade White)  |  |                                      |   |  | 2. Date of De<br>Month<br><b>May</b> | Day        | Year 2008                   | 3. Time of Death 4:00 P                            |
|                     | Examin   |                | 4a. Facility Name (If not institution, give 1513 Cochran Road  |  |                                      |   | or Location of Dea                                   | th                                   | 4c.        | County of Death  Harford    | d  |
|                     | Funeral<br>Director  |                | 5. Social Security Number 6. Sec. 12 6. Sec. | 7. Age<br>⊀M 2□F   | (In yrs. last birthday) 50 Yrs.      | If Under 1 Year<br>Months Days                          | If Under 24 Hrs                                      |                                      | y, Year)   | Cour                        | olace (State or Foreign<br>aryland                 |
| 0.00                | aryland<br>show<br>d at  | _              | Usual Residence of Decedent  10a. State  10b. County   |  | 10c. City, Town or Lo                | ocation   |  |                                      |            | 1                           | 0d. Inside City Limits 1 ☐ Yes 2 🕱 No              |
|                     | with the Maryland<br>a or 28a-f show<br>the notified at  | Director       | Maryland Harfo   | ord  | Jo                                   | ppa<br>10f. Zip Code                                    |  |                                      | 10g. Citiz | zen of What Cour            |  |
|                     | ns 23a o<br>must b   |                | 1511 Cochran Road  | 12. Was Decedent E   | vor in II S 12                       |   | 1085   | Specify Ves or No                    |            | USA<br>14. Race - Americ    | an Indian  |
| / 980               | n 72 hours after death with the Maryland<br>"natural", or items 23a or 28a-f show<br>edical Examiner must be notified at   | by Funeral     | 11. Marital Status  1 ∑Never Married 2 Married 3 Widowed 4 Divorced  | Armed Forces?  1 Yes 2 N If Yes, Give Year or Dates:                         | ver in 0.3.                          | Was becedent of<br>If Yes, specify Cu<br>1 ☐ Yes 2 X No | Hispanic Origin? (:<br>ban, Mexican, Pue<br>Specify: | rto Rican, etc.)                     |            | Black, White, Specify: Wh:  | etc.   |
| Maryland 21215-0036 | be filed within 72 hou<br>tal Hygiene.<br>d other than "natura<br>event, the Medical E   | Completed      | 15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12)   | cation<br>e completed)<br>College (1-4or 5-                                  | (Give                                |   | e during most of wo<br>ed)                           | orking                               | 16b. Ki    | nd of Business/In           |  |
| 121                 | filed wit<br>Hygiene<br>ther the   |                | 12 17. Father's Name ( <i>First, Middle, Last</i> )  |  | Ass                                  | sembly Wo   | 1  | me (First, Middle                    |            |                             | Manufacture  |
| lanc                | ild be fi<br>lental H<br>ked ot<br>ic ever   | To Be          | Billy Gerald White   | ely Sr.  |                                      |   |  | laine Ep                             |            | ,                           |  |
| Aary                | ss 1 and 2 should be filed vof Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other trother traumatic event, the                          |                | 19a. Informant's Name/Relationship (7)   | •  |                                      | •   | t and Number or F                                    |                                      |            |                             | Code)  |
| re, l               | s 1 and<br>of Health<br>item 27<br>other t   |                | Gay E. Whitely / 1 20a. Method of Disposition  |  | 20b. Place of Disp                   |   |  | Date Date                            |            | cation - City or Te         | own, State   |
| Baltimore,          | Page<br>ment<br>ant: If<br>ury o   |                | 1 ☑ Burial 2 □ Cremation 3 □ F<br>4 □ Donation 5 □ Other (Specify)   |  | Bel Air                              | Memorial  | Gdn 5-2  | 29-08                                | Be]        | Air, Ma                     | aryland  |
| Balt                | permit. E<br>Departm<br>Importar<br>any injur  |                | 21. Signature of Funeral Service Licens  | vegly  |                                      | 1317 Cok  | Funeral I<br>esbury Ro                               | l., Abing                            | gdon       | , MD 21 <u>0</u> 0          |  |
|                     | Physician<br>/Medical<br>Examiner  |                | 23a. Pant1. Einer the disease, or composhock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)   | a Kidu   | the death. Do not ene.               | iter the mode of dy                                     |  | ac or respiratory a                  | ırrest,    |                             | Approximate<br>Interval Between<br>Onset and Death |
| S. Color            | 2  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | C  | consequence of):                     |   |  |                                      |            |                             |  |
| 68760,              | ficate be<br>physicia<br>s the bur   | edical         |  | d  |                                      |   |  | ·                                    |            |                             |  |
| P.O. Box (          | The law requires that the death certificate be executed the has been signed by the attending physician and oage 2 should be detached for use as the burial-transit | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant<br>in the past 12 months?<br>1 □ Yes 2 □ No<br>9 □ Unknown  | 23c. If yes, outcome p<br>1 □ Live birth 2<br>4 □ Pregnant at<br>9 □ Unknown | 2 ☐ Fetal death 3                    | □Ectopic pregnan □ Other (specify)                      | су   |                                      |            | 23d. Date of deliv<br>Month | ery<br>Day Year                                    |
| rds, P              | quires that<br>n signed b<br>ald be deta   | þ              | Part II. Other significant conditions co   | ntributing to death bu   | t not resulting in the u             | underlying cause g                                      | iven in Part I.                                      |                                      | ~          | -A*                         | he cause of death?<br>bably 4 □Unknown             |
| or Vital Records,   |  | Completed      |  |  |                                      |   |  | 24a. Was<br>auto<br>perf<br>1∐ Yes   |            | prior to co                 | opsy findings available impletion of cause of      |
| Vita                | slcian:<br>certific<br>rector,   | Be             | 25. Was case referred to medical examiner? 1 ☐ Yes 254 No  | Hospital:  | nt 2∏ER/Outpatie                     | m 351000 0  | ther.  | eath (Check only                     |            | 2.75mm                      | Motherla   |
| on or               | ding Phy<br>After this<br>funeral d  | tion: To       | 1 Yes 25 No  27. Manner of Death  Natural 5 Pending investigation  | 1 ☐ Inpatier  28a. Date of Injur  (Month, Day                                | y 28b. Time                          | of 28c. Inj   |  | Home 5 Res                           |            |                             | Mother's esidence                                  |
| Division            |  | Certification: | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28e. Place of injubulding, etc   | ry - At home, farm, s<br>. (Specify) | treet, factory, office                                  | 9  | 28f. Location<br>City or To          |            |                             | al Route Number,                                   |
|                     | e Hospital or<br>124 hours afte<br>e Funeral Dir<br>letely filled in   | Medical C      |  | sician: To the best of<br>iner: On the basis of<br>and manner sta            | examination and/or i                 |   |  |                                      |            |                             |  |
|                     | To the within 2 To the comple  | Me             | 29b. Signature and title of certifier.   |  | 1                                    | 29c. Lice   | nse number   | 4449                                 | 29d. Da    | te signed (Month,           | Day, Year)   |
|                     | (  |                | 30) Name and address of person who c   | ompleted cause of de   | eath (Item 23a) (Type                | , Print)  |  |                                      | מצ         | EIKI                        | UN 762   |
|                     | Sta  | ite            | 31. Date filed (Month, Day Year)   | 2 Benjetra   | r's signatur                         | 119   | A UT.  | MITE                                 | 200        | UIITA                       | A PWOUL  |

DHMH 17 Rev 1/2001

# Patient Known as: JOHN FRANCIS WILSON Baltimore, Maryland 21215-0036

|  |  | ,                           | State Registrar   | of Maryland / Dep  | eartment of Health and ertificate of Death  | Mental Hygien                        | e2008  | 17252                          |  |
|--|--|-----------------------------|---|--|---|--------------------------------------|--|--------------------------------|--|
|  | Physici<br>/Medic  |                             | 1. Decedent's Name (First, Middle, Last)  Tohn Frances  | Wilson   | Timodio of Bodin  | 2. Date of Death                     | ay Year  | 3. Time of Death               |  |
| The state of   | Examin   |                             | 4a. Facility Name (If not institution, give street and SINAL HOSPITAL OF B  |  | 4b. City, Town, or Location of Deal Roll timere City  | th 4                                 | c. County of Death   |                                |  |
|  | Funeral<br>Director  |                             | 5. Social Security Number 219. 26. 8447  Usual Residence of Decedent  | 7. Age (In yrs. last birthday  |   |                                      | 9. Birthp<br>Coun  | lace (State or Foreign<br>try) |  |
| nore, Maryland 21215-0036  | Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hyglene. int: If item 27 is marked other than "natural", or items 23a or 28a-f show yo other traumatic event, fre Madical Examiner must be rediffed at my or other traumatic event, fre | Funeral Director            | 10a. State  MD  Baltimore   | 10c. City, Town or L   | A 4 1 1   |                                      | 1  | 0d. Inside City Limits         |  |
|  |  |                             | 10e, Street and Number  | -  | 10f. Zip Code   | 10g. C                               | Citizen of What Coun   |                                |  |
|  |  |                             |   | ecedent Ever in U.S. 13.   | . Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue                          | Specify Yes or No-                   | USA<br>14. Race - Americ   |                                |  |
|  |  | þ                           | 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes,<br>3 ☐ Widowed 4 ☐ Divorced Year o   | s 2 No<br>Give<br>r Dates:   | 1 □ Yes 2 🚾 o Specify:  |                                      |  | ack                            |  |
|  |  | To Be Completed             | 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College 1210 Qyadl   | (Give  | edent's Usual Occupation e kind of work done during most of wo DO NOT use retired) AAChine Operat | orking 6                             | Kind of Business/Ind<br>Veensprin<br>Dan                                       | g Milk                         |  |
|  |  |                             | 17. Father's Name (First, Middle, Last)  Frank Wilson   |  | 18. Mother's Na   | me (First, Middle, Maide<br>3 Canoll | n Surname)   |                                |  |
|  |  |                             | 19a. Informant's Name/Relationship (Type. Print) Ruth J. J. Wilson/W  | 19b. Mail  | ling Address (Street and Number or F  | Rural Route Number, City             |  | Code)<br>D 21244               |  |
|  |  |                             | 20a. Method of Disposition  128urial 2 ☐ Cremation 3 ☐ Removal fro  | 20b. Place of Disp cemetery, cre   |   | Date 20c.                            | Location - City or To  |                                |  |
| Baltimore,   | permit. Page<br>Department of<br>Important: If<br>any injury or<br>once.   |                             | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee   | I King M   | 22. Name and Address of Facility  | ughn C. Gree                         | indoor 1   | al sowices                     |  |
|  | Physician and // Medical Examiner private transit  | ical Examiner               | 23a. Part 1. Enter the disease, or complications that   | at caused the death. Do not er   | 8728 Liberty Roa<br>nter the mode of dying, such as cardia  |                                      | stown MI   | Approximate Interval Between   |  |
|  |  |                             | resulting in death)   | EPTIC SHOCK  |   |                                      |  | Onset and Death                |  |
|  |  |                             | P   | to (or as a consequence of):   |   |                                      |  | 3 days                         |  |
|  |  |                             | cause. Enter Underlying Cause (Disease or injury that initiated events  | to (or as a consequence of):   | cell lymphoma   |                                      |  | Jyear                          |  |
|  |  |                             | resulting in death) Last Due  | to (or as a consequence of):   | <b>X Y</b>  |                                      |  |                                |  |
|  |  |                             | 23b. was decedent pregnant  | outcome of pregnancy<br>ve birth 2 ☐ Fetal death 3                                     | ☐ Ectopic pregnancy   |                                      | 23d. Date of delive  |                                |  |
| P.O. B   |  | by Physician/Med            | in the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown  |  | 5 ☐ Other (specify)   |                                      | Month Day Year   |                                |  |
| ds, F  | uires that<br>signed to<br>d be deta   |                             | Part II. Other significant conditions contributing to   | death but not resulting in the   | underlying cause given in Part I.   |                                      | o use contribute to the  | ne cause of death?             |  |
| Records,   | To the Hospital or Attending Physician: The law requir within 24 hours after death.  To the Funeral Director. After this certificate has been s completely filled in by the funeral director, page 2 should  | Completed                   | Polmonory embolism 24a.   |  |   | 24a. Was an autopsy                  | utopsy prior to completion of cause of   |                                |  |
| ital F   |  | 0                           | performed? death? 1 □ Yes 2 □ No 1 □ Yes  25. Was case referred to medical 26. Place of Death (Check only one)  |  |   |                                      | 2 12 No  |                                |  |
| ivision  |  | Medical Certification: To B |   | Inpatient 2 ☐ ER/Outpatie  | ent 3 DOA Other: 4 Nursing  | Home 5 ☐ Residence                   | 6 ☐ Other (Specia  | y)                             |  |
|  |  |                             | 27. Manner of Death  1 Natural 5 Pending (M) 2 Accident investigation   | ate of Injury<br>fonth, Day, Year) 28b. Time<br>Injury                                 |   | 28d. Describe how inj                | ury occurred   |                                |  |
|  |  |                             | 3 Suicide 6 Could not be 28e. Pla   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |                                      | 8f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |                                |  |
|  |  |                             | 29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |                                      |  |                                |  |
|  |  |                             | 29b. Signature and the processiver . MBBS   |  | 29c, License number   |                                      | Date signed (Month,  |                                |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) |  |                             |   |  |   | ,, , & _, &                          |  |                                |  |
| State 31. Date filed (Month, Day, Year) 32. Figistrar's Signature                    |  |                             |   |  |   |                                      |  |                                |  |
| Registrar IVIA 1 & 0 2000 Julius St. Appell  |  |                             |   |  |   |                                      |  |                                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygier 8

1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician 6:43 1683 SUCE WALLEICH 12/9 /Medical a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner DURY LARM UNIVERSITY O TIMIA Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 12/20/1930 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 150M 2□ F Months Days Hours 218-26-6002 Mary1and Director Usual Residence of Decedent 10a. State 10b County 10c. City Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylar nent of Heatth and Mental Hygiene.
ant: if Item 27 is marked other than "natural", or Items 23s or 28e-1 show Lry or other treumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 703 Glenview Avenue 21061 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Marned Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Mechanic Long Shoreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Linwood Webb, Sr. Helena Elizabeth Holmes 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 703 Glenview Avenue, Glen Burnie, MD 21061 Webb/wife Gladys 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veterans
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: if ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue, S.W. Glen Burnie, MD 21061 Hwall Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MIGRASARTU HEMORRHAGE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner WTAPOLUBAG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transi 1420mbocto PENIA that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760,<sup>7</sup> Physician/Medical STATEAT phys IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo Month in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has page 2 autopsy certificate 1 ☐ Yes : After this certifical funeral director, I or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending within 24 hours after death.

To the Funeral Director: At completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28I Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) 2103 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1.19 GOSSUS HESLER 32 Registrar's Signature 31. Date filed (Month, Day, Year) WAY 2 8 2008 State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month William 2008 3:00A M Wicklein May 26, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Tate Hospice Hospital Linthicum Anne Arundel Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Jan • 19, **Funeral** Months 88 1 XM 2□ F 212-03-2692 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 102 Three Coin Way Apt.204 21061 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces? 1 X Yes 2 □ No If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No White Completed by Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steamfitter Utilities 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John W. Wicklein Lula Bailey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Stella Connor /Daughter 837 White Avenue Linthicum, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May Data 0. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2008 Glen Burnie, MD 22. Name and Address of Facility 21 Signature of Funeral Service Licensee 200918 Singleton Funeral & Cremation Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to find clat-cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Physician/Medical Examiner sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1□ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ZNo 2 ER/Outpatient 3 DOA 6 🗷 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. 28d. Describe how injury occurred Injury at Work? Hospital or Attending | Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Seell 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar MAY 2 8 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 17255 1 - For State Registrar

| Physician |
|-----------|
| /Medical  |
| Examiner  |
|           |

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760, 3

|                                     | 1. Decedent's Name   | e (First, Middle,                        | Last)  |                            |                                 |  |                               |                      | 2. Date of De                     |                          | V                                 | 3. Time of Death                                   |
|-------------------------------------|--|--|--|----------------------------|---------------------------------|--|-------------------------------|----------------------|-----------------------------------|--------------------------|-----------------------------------|--|
| n                                   | Robert   |  | Stewart  |                            | Warnke                          | n  |                               |                      | Month<br>May                      | 25,                      | 2008                              | 4:19A M  |
| al<br>er                            | 4a. Facility Name (/   | f not institution, g                     | give street and number)                              |                            |                                 | 4b. City, Town, o                                | Location of                   | Death                | -                                 | 4c. (                    | County of Death                   |  |
|                                     | 701 Ship   | ley Cour                                 | :t   |                            |                                 | Linthi   | cum                           |                      |                                   | An                       | ne Arund                          | le1  |
|                                     | 5. Social Security N   |  |  | e (In yrs. I               | ast birthday)                   | If Under 1 Year<br>Months Days                   | If Under 24<br>Hours          | 4 Hrs                | 8. Date of Bir<br>(Month, Da      | v. Year)                 | Coui                              | place (State or Foreign '                          |
|                                     | 212-03-40  | 029                                      | 1 <b>X</b> M 2□F                                     | 90                         | Yrs.                            |  |                               |                      | Oct.1,                            | 191                      | 7                                 | MD   |
|                                     | Usual Residence of<br>10a. State                                 | Decedent<br>10b. County                  |  | 10c City                   | , Town or Lo                    | cation   |                               |                      |                                   |                          |                                   | 10d. Inside City Limits                            |
| ř                                   | MD   | Anne Ar                                  | rundo 1  |                            | thicum                          |  |                               |                      |                                   |                          |                                   | 1 ☐ Yes 2 ☑ No                                     |
| ecto                                | 10e. Street and Nu   |  | diaci  | DIL                        | CITTCUI                         | 10f. Zip Code                                    |                               |                      |                                   | 10a Citia                | zen of What Cou                   | ntn/?  |
| ģ                                   | 701 Ship   |  | • <del>+</del>                                       |                            |                                 | 2109   | 1                             |                      | i                                 | U.S                      |                                   | my:  |
| To Be Completed by Funeral Director |  | rey cour                                 | 12. Was Decedent                                     | Ever in II                 | S 13 1                          |  |                               | in? (Sne             | cify Yes or No                    |                          | 14. Race - Americ                 | can Indian.  |
| Š                                   | 11. Marital Status   | ried 2 Married                           | Armed Forces?  |                            |                                 | Was Decedent of H<br>If Yes, specify Cub         | an, Mexican,                  | Puerto               | Rican, etc.)                      |                          | Black, White,                     |  |
| ρ                                   | 3 ☐ Widowed  |  | If Yes, Give<br>Year or Dates:                       |                            | 1                               | 1 ☐ Yes 2X No                                    | Specify:                      |                      |                                   |                          | Specify: Whi                      | Lte  |
| pe l                                |  | 15. Decedent's                           | Education  |                            | 16a. Deced                      | dent's Usual Occup                               | ation                         | . 4                  |                                   | 16b. Kir                 | nd of Business/In                 | ndustry  |
| ble                                 | Elementary/Seco  |  | grade completed)  College (1-4or 5                   | 5+)                        | life. I                         | kind of work done<br>DO NOT use retire           | during most (<br>d)           | ot workii            | ng                                |                          |                                   |  |
| Ĕ                                   | '9   | , (0 /2,                                 |  | ,                          | Sales                           |  |                               |                      |                                   | ]                        | Retail_                           |  |
| 3e C                                | 17. Father's Name  |  | ,  |                            |                                 |  |                               |                      | (First, Middle                    | , Maiden                 | Surname)                          |  |
| ပို                                 | Harry L.   | Warnker                                  | 1  |                            |                                 |  | Bert                          | ha I                 | Bishop                            |                          |                                   |  |
| •                                   | 19a. Informant's N   |  |  | _                          |                                 | ng Address (Street                               |                               |                      |                                   |                          |                                   | ·  |
|                                     | Mrs. Lil   | lian M.                                  | Warnken/ Wi  |                            |                                 | Shipley  |                               |                      |                                   |                          | <u> </u>                          |  |
|                                     | 20a. Method of Disp  |  | 3 □Removal from State                                | 20b. P                     | lace of Dispo<br>emetery, crei  | sition (Name of matory or other pla              | ce) l                         | May                  | 29,                               |                          | cation - City or T                |  |
|                                     |  | 5 ☐ Other (Spe                           |  | C                          | edar H                          | ill Cemet  | ery                           | 200                  | )8                                | Bro                      | ooklyn,                           | MD   |
|                                     | 21. Signature of Fu  | uneral Service Li                        | censee Mov   | 918                        |                                 | 2. Name and Addre                                |                               | OTI                  | gleton                            | Fune                     | eral & C                          | remation   |
| -(                                  | 700  | HUOS                                     | (Cu)   |                            |                                 |  |                               |                      |                                   |                          | Burnie,                           | MD 21061   |
|                                     | 23a. Part1. Enter t<br>shock, or hea                             | the disease, or c<br>art failure. List o | omplications that caused<br>nly one cause on each li | d the death<br>ne.         | n. Do not ent                   | er the mode of dyi                               | ng, such as c                 | ardiac c             | or respiratory a                  | ırrest,                  |                                   | Approximate<br>Interval Between<br>Onset and Death |
|                                     | Immediate Cause disease or condition                             | (Final<br>on                             | _a 1310  | NC                         | 177                             | 5  |                               |                      |                                   |                          |                                   | 5 DAYS   |
|                                     | resulting in death)  | - (                                      | Due to (or as  | a consequ                  | uence of):                      |  |                               |                      | -2                                |                          |                                   |  |
| <u>.</u>                            | Sequentially list co   | onditions,                               | b. Cltno   | 274                        | _ Or                            | 3177   | nu                            | 1                    | 200                               | DUA                      | 1 my                              | 20 yrang   |
| an/Medical Examiner                 | if any, leading to in<br>cause. Enter Under<br>Cause (Disease or | erlying<br>r injury                      | 200 10 (01 82  | a consequ                  | derice org.                     | 1)   | 13/7 1                        | 75 I                 | Ż                                 |                          |                                   |  |
| xan                                 | that initiated events<br>resulting in death)                     | s  | c<br>Due to (or as                                   | a consequ                  | uence of):                      |  |                               |                      |                                   |                          |                                   |  |
| alE                                 |  |  |  |                            |                                 |  |                               |                      |                                   |                          |                                   |  |
| edic                                | ( <del>-</del>   |  | d  |                            |                                 |  |                               |                      |                                   |                          |                                   |  |
| Ž                                   | IF FEMALE:<br>23b. Was deceden                                   | nt pregnant                              | 23c. If yes, outcome                                 |                            |                                 |  |                               |                      |                                   |                          | 23d. Date of deliv                | very   |
|                                     | in the past 12   | 2 months?                                | 1□Live birth<br>4□Pregnant a                         |                            |                                 | ⊒Ectopic pregnanc<br>⊒Other (s <i>pecify</i> ) _ | y<br>                         |                      |                                   |                          | Month                             | Day Year   |
| hys                                 | 9 □ Unknowr  |  | 9∐Unknown  |                            |                                 |  |                               |                      |                                   |                          |                                   |  |
| Ϋ́                                  | Part II. Other signi   | Ificant condition                        | ns contributing to death b                           | ut not resi                | ulting in the u                 | nderlying cause giv                              | en in Part I.                 |                      | 23e. Did                          | tobacco u                | se contribute to                  | the cause of death?                                |
| pe                                  |  | -  |  |                            |                                 |  |                               |                      | 1 🗆                               | Yes 2[                   | □No 3 Pro                         | babiy 4 Unknown                                    |
| oleti                               |  |  |  |                            |                                 |  |                               |                      | 24a. Was                          |                          | 24b. Were aut                     | opsy findings available                            |
| Completed by Physic                 |  |  |  |                            |                                 |  |                               |                      | auto<br>perf<br>1□ Yes            | ormed?<br>2 No           | death?                            | ompletion of cause of<br>2 ☐ No                    |
| Be C                                | 25. Was case refe  | rred to medical                          |  |                            |                                 |  | 26. Place                     | of Death             | h (Check only                     |                          | 1                                 |  |
| O B                                 | examiner?  | No                                       | Hospital: 1   Inpati                                 | ent 2 🗆                    | ER/Outpatier                    | nt 3□ DOA Oth                                    | er: 4 ☐ Nur:                  | sing Ho              | me 5 Des                          | idence (                 | 6 ☐Other (Spec                    | ify)   |
| ü                                   | 27. Manner of Dear   | 5 ☐ Pending                              | 28a. Date of Inju<br>(Month, Da                      | ıry<br>ıy Year)            | 28b. Time o<br>Injury           | f 28c. Inju<br>Wo                                | ry at<br>rk?                  |                      | 28d. Describe                     | how injur                | y occurred                        |  |
| atio                                | 1 Natural 2 Accident   | investiga                                | ation  | ===                        |                                 | M 1 🗆  | Yes 2□N                       | lo                   |                                   |                          |                                   |  |
| tific                               | 3 ☐ Suicide<br>4 ☐ Homicide                                      | 6 ☐ Could no<br>determin                 |  | ury - At ho<br>tc. (Specif | ome, farm, str                  | reet, factory, office                            |                               |                      |                                   | (Street an<br>wn, State  |                                   | ral Route Number,                                  |
| Cer                                 |  |  |  |                            |                                 |  |                               |                      |                                   |                          |                                   |  |
| Medical Certification: To           | 29a. Certifier<br>(Check only                                    | 1 Certifying 2 Medical E                 | Physician: To the best<br>xaminer: On the basis of   | of examina                 | wledge, deat<br>ition and/or in | h occurred at the ti<br>vestigation, in my       | me, date and<br>opinion, deat | d place,<br>th occur | and due to the<br>red at the time | e cause(s)<br>, date and | and manner as<br>d place, and due | stated.<br>to the cause(s)                         |
| Med                                 | one) 29b. Signature  | d title of cortifier                     | and manner st  | ated.                      |                                 | 29c. Licens                                      | e number                      |                      |                                   | 20d Dat                  | te signed (Month                  | Day Voorl  |
| _                                   | 29b. Signature and   | d line of certifier                      | / ,  |                            |                                 |  |                               |                      |                                   |                          |                                   |  |
|                                     |  | X  | 1  |                            |                                 | 1012   | . 1                           | 4 1                  | /                                 |                          |                                   |  |
|                                     | Al   | ~ /                                      |  |                            |                                 |  | 783                           | 7 Y                  |                                   | 1/17                     | 4 28,                             | 2008   |
|                                     |  |  | vho completed cause of o                             | death (Iten                | n 23a) (Type,                   | Print)   | / 8 ·                         | -^                   |                                   | ' /1 <u>&gt;</u>         | 4 28,                             | 2008   |
|                                     | JOH  | V S11                                    | MYZNIA   | 0                          | n 23a) (Type,                   | Print)   | TINA                          | ו נפו                | 130                               | , 4                      | 4 28,<br>11770                    | 2008<br>: UN, MM                                   |
| te<br>ar                            |  | V S11                                    | MANZMS 1   | rar's Signa                | n 23a) (Type,                   | Print)   | MINA                          | ונצו                 | 130                               | , 61                     | 4 28,<br>NITTI                    | 2008<br>:UN, MM                                    |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 50N 6:16 PM MAY 2008 ESTER 19 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NIA Baltimore Huspital Bon Secour If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Country) U.S.A Social Security Number **Funeral** 59 1 M 2 □ F N.C. Aug 03, 1948 214-50-3685 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1XYes 2 No Baltimore MD Funeral Director the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21229 I.N. Beechfield Apt) Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes → No Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any Injury or other traumatic event, the Mary Injury or other traumatic event, the Mary Injury or other traumatic event. rood Transporter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilson Magnolia Long ၉ Lester James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore MD 21229 Brisbrune Rd eslie A. Maker/daughter 566 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Bunal 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mt. Carmel Cemetery May 24, 2008 Dundalk,

22. Name and Address of Facility

Ronald A Chryson Funeral Service

270 Frey Hiltin Pars, 13ce in more, MD Dundack, Maryland 21. Signature of Funeral Service Licensee mald 21229 Graysor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PNUEIMONIA BILATERAL Physician /Medical Due to (or as a consequence of): **Examiner** ACUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner DISEASE as the burial-transil ARTERIOSCLEROTIC The law requires that the death certificate be executed attending physician and for use as the hurial trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IE EEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown HYPERTENTION 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No MEILITMS 24a. Was an autopsy performed?
1□ Yes 20 No page 2: 1∐ Yes **らひおよてみかとた** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: Hospital: 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 7 No 1 🕅 Inpatient Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 A Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 ☐ Suicide 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 223300 2008 MD. SELDURS 130N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO, ST, PATEZ DUDHIR. 2000 W.

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 2 8 2008

Anert

32. Refistrar's Signature

|   |   | -              | For<br>State<br>Registrar   | State o                                | of Maryland  |   | rtment<br><i>tificate</i>                  |                                |                                  |                 | lental l                   |                                       | ene<br>g. No. <b>2 0</b>                  | 08  | 17257   |
|---|---|----------------|---|--|--|---|--|--------------------------------|----------------------------------|-----------------|----------------------------|---------------------------------------|---|---|---|
|   | Physicia<br>/Medic  | an             | 1. Decedent's Name (First, Midd<br>FAY WORTO  | ,                                      |  |   |  |                                |                                  |                 | 2. Date of Month           | f Death                               |   | Year  | 3. Time of Death<br>6:00 a M  |
|   | Examin  | _              | 4a. Facility Name (If not institution RAVENWOOD NUR   | -                                      | ımber)   |   | 4b. City, To                               | own, or L<br>LTIM              |                                  | of Death        |                            |                                       | 4c. County                                | of Death                                      |   |
|   | Funeral<br>Director   |                | 5. Social Security Number 579-11-4379   | 6. Sex<br>1 ☐ M 2 ☐ <b>x</b> F         | 7. Age (In yrs. I<br>82  | ast birthday)<br>Yrs.                         | If Under 1<br>Months                       | Year<br>Days                   | If Under<br>Hours                | 24 Hrs.<br>Min. | 8. Date o<br>(Month<br>MAY | f Birth<br>, Day,                     | Year)<br>1926                             | Coun  | lace (State or Foreign<br>try)<br>IINGTON DC                        |
| Maryland  | f show<br>led at  | tor            | Usual Residence of Decedent   |  | 10c. City  | , Town or Lo                                  | cation<br>ALTIMOR                          | RE                             |                                  |                 |                            |                                       |   | 1   | 0d. Inside City Limits 11 Yes 2 No                                  |
| h with the  | 23a or 28a<br>st be notif   | al Director    | 10e. Street and Number 501 WEST FRAN  | KLIN STRE                              | ET   |   | 10f. Zip C                                 |                                | 1201                             |                 |                            | 10                                    | g. Citizen of USA                         |   | try?  |
| :1215-0036<br>within 72 hours after death with the Maryland | if of Health and Mental Hygiene.<br>If flem 27 is marked other than "natural", or items 23a or 28a-f show<br>or other traumatic event, the Medical Examiner must be notified at | by Funeral     | 11. Marital Status  1    ↑ Never Married 2   Ma  3   Widowed 4   Divorce  | Armed F<br>med 1 ☐ Yes<br>If Yes. G    | 2 No   |   | Was Decede<br>f Yes, specif<br>1 □ Yes 2E  |                                | panic Or<br>, Mexica<br>Specify: |                 | ecify Yes o<br>Rican, etc  | or No-                                |   | ce - Americ<br>ck, White,<br>y: WHI           | etc.  |
| <b>21215-0036</b> d within 72 hours af                      | ne.<br>than "nature<br>Medical E  | Completed      | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)<br>7th GRADE  | nt's Education<br>est grade completed, | )<br>(1-4or 5+)  | (Give<br>life. L                              | tent's Usual<br>kind of work<br>DO NOT use | Occupat<br>done du<br>retired) | tion<br>uring mos                | st of worki     | ing                        | 1                                     | 6b. Kind of B                             |   | dustry  |
| should be filed v   | lental Hygie<br>rked other t<br>ilc event, th   | To Be Co       | 17. Father's Name (First, Middle PETER WORTON   | , Last)                                |  | 110112  |  |                                | 18. Moth                         |                 | (First, Mi                 |                                       | aiden Surnar                              |   |   |
| and 2 should be file  | ealth and N n 27 Is mainer traumai  |                | 19a. Informant's Name/Relation  |  |  | 1271  | 8 NET                                      | TLES                           |                                  | NEW.            | PORT                       | NEW                                   |   | 2360  | 6   |
| Daltimore,<br>bermit. Pages 1 at                            | int:  |                | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (  | Specify)                               | n State  | Place of Dispo<br>emetery, cres               | CEMET                                      | er place<br>ERY                | 5                                | /29/            |                            | P                                     | ETERSE                                    | URG,  | VA  |
| permit.   | Depar<br>Impor<br>any In  |                | 21. Signature of Funeral Service  | ay tau                                 | (ISM)  | 8   |  | OCH I                          | RAVE                             | N BL            | VD. T                      | OWS                                   | ON, MD                                    |   | OME P.A.  Approximate Interval Between                              |
| /   | physician and Medical xaminer s the prival-transit  | dical Examiner | 23a Part1. Enfer the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. Due to                              | O (or as a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (or a consequence o (o | uence of):                                    | en   | اد                             |                                  | N.              | 'lu                        |                                       |   |   | Onset and Death   |
| requires that the death certifica                           | signed by the attending ph<br>d be detached for use as th   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   | 1 ☐ Live                               | utcome pf pregna<br>birth 2 □ Feta<br>gnant at time of d<br>nown   | Ideath 3[                                     | ⊒Ectopic pre<br>⊒Other <i>(spe</i>         |                                |                                  |                 |                            | _                                     |   | ate of delive                                 | ery<br>Day Year   |
| equires that  | been signed b<br>should be deta   | þ              | Part II. Other significant condi  | tions contributing to                  | death but not resi   | ulting in the u                               | nderlying cau                              | use give                       | n in Part                        | l.              |                            |                                       |   |   | he cause of death?  |
| aw  | 2 st  | Completed      | Kear  | arri                                   | rytu   | u'a   |  |                                |                                  |                 |                            | Was an<br>autopsy<br>perform<br>(es 2 | 24b.<br>1ed?                              | Were auto<br>prior to co<br>death?<br>1 ☐ Yes | psy findings available<br>mpletion of cause of<br>2 <del>☐ No</del> |
| Physician:  | his certific  | To Be          | 25. Was case referred to medic examiner? 1 ☐ Yes 2 ☐ No   | Hospital: 1                            | Inpatient 2  |   |  | Othe                           | r: 4⊡ <del>N</del>               | ursing Ho       |                            | Reside                                | nce 6 □Ot                                 |   | <i>(y)</i>  |
| l or Attending Physician: The law requires t                | ifter death.  Director: After in by the funer   | Certification: | 3 Suicide 6 Could   | ing (Mo                                | e of Injury<br>onth, Day Year)<br>ce of injury - At ho<br>ding, etc. (Specif   | 28b. Time o<br>Injury<br>ome, farm, sti<br>y) | M  |                                | at<br>?<br>′es 2 ⊑               | ]No             | 28f. Locat                 | ion (Str                              | w injury occu<br>reet and Num<br>, State) |   | al Route Number,  |
| L<br>he Hospital  | in 24 hours<br>he Funeral<br>pletely filled   | Medical C      |   | ing Physician: To the<br>and ma        |  |   |  |                                |                                  |                 |                            |                                       |   |   |   |
| To the  |   | Σ              | 29b. Signature and title of certif  | M so u                                 | 16 C   | M_D   | 29c.                                       |                                | number 78                        | 04              |                            |                                       | od. Date sign                             | - 1   | Day, Year)  |
|   | 3   | g y            | 30. Nome and a diess of erso  | ec 16                                  | A ben  | n 23a) (Type,                                 | Print)                                     | 22                             | Q                                | Ab.             | erd                        | 100                                   | u T                                       | 10  | 21001   |
|   | Sta<br>Registi  |                | MAY 2   | 8 2008                                 | Registrar's Signa  | y A   | cole                                       |                                |                                  |                 |                            |                                       |   |   |   |

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Them 10c per fh 9879 5-28-08 vt.
State of Maryland / Department of Health and Mental Hygiene 088 17258 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2008 Month MAY 1:45P M WALDER MELVIN 4c. County of Death 4b. City, Town, or Location of Death BALTIMORE PIKESVILLE

/Medical

**Physician** 

/Medical burial-trai physician the burial attending p been signed by the should be detached page 2 s After n 24 hours after death.

le Funeral Director: A pletely filled in by the fu

4a. Facility Name (If not institution, give street and number) Examiner BRIGHTON GARDENS OF PIKESVILLE 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex. **Funeral** Months Days 10/19/1920 219-01-7346 87 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 28a-f show PIKESVILLE ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No REISTERSTOWN Director BALTIMORE 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number USA 21208 1840 REISTERSTOWN ROAD Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status WHITE 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛣 No Baltimore, Maryland 21215-0036 Specify: ģ 3 □XWidowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na: any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION CHAUFFER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be BLUMBERG LILLIAN WALDER CHARLES ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3216 SMITH AVENUE, PIKESVILLE, MD 21208 CHARLES WALDER / SON 20b. Place of Disposition (Name of complex cremators or char place)
ANSHE CHAIM CONG. 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 05/25/2008 BALTIMORE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Disease **Physician** disease or condition 91411507 Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Dementia Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 Tes 2 Mo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier may 23, 2008 Haus J. Bulrtt, M. DOOS8676

DHMH 17 Rev 1/2001

State Registrar 4000 ad cowt load, suite 30,

Baltmore MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Babitt, M.D.

31. Date filed (Month, Day, Year) 2008

|               |   |               | For<br>State<br>Registrar   | State of Ma   | arylan       | d / Depa<br><i>Ce</i> a        | artment of F<br>rtificate of                       | lealth and I<br>Death                     | Mental Hy                                | giene<br>Reg. No.   | 20                      | 08                           | 17259                                   |
|---------------|---|---------------|---|---|--------------|--------------------------------|--|---|--|---------------------|-------------------------|------------------------------|---|
|               | Physicia  | an            | 1. Decedent's Name (First, Middle, Las  | st)   |              |                                |  |   | 2. Date of De                            | ath                 |                         | Year                         | 3. Time of Death                        |
| _             | /Medic  |               | Frank J. Zmuda  |   |              |                                |  |   | May 17                                   | , 20                | 08                      |                              | 10:50 P <sub>•M</sub>                   |
|               | Examin  | ier           | 4a. Facility Name (If not institution, give 1712 Lorre Drive                  | e street and number)  |              |                                | 4b. City, Town, o                                  | r Location of Death                       |  |                     | ntgo                    |                              |   |
|               | Funeral   |               | 5. Social Security Number 6. S  |   | e (In yrs. i | last birthday)                 | If Under 1 Year                                    | If Under 24 Hrs.                          | 8. Date of Bir                           | _                   |                         | 9. Birthp                    | ace (State or Foreign                   |
|               | Director  |               | 168-32-3637   | <b>⊠</b> M 2□ F   | 70           | Yrs.                           | Months Days  | Hours Min.                                | 8. Date of Bir<br>(Month, Da<br>April 5, | 1938                |                         | Penn                         | sylvania                                |
| 7             | ariu<br>BW  |               | Usual Residence of Decedent  10a. State 10b. County                           |   | 10c. Cit     | y. Town or Lo                  | cation   |   |  |                     |                         | 10                           | Od. Inside City Limits                  |
| Many          | -f sho  | tor           | Maryland Montgom  | erv   |              | ville                          |  |   |  |                     |                         |                              | 1⊠Yes 2□No                              |
| \$<br>\$      | r 28a   | Director      | 10e. Street and Number  | 01)   | 10010        |                                | 10f. Zip Code                                      |   |  | 10g. Cit            | izen of W               | hat Coun                     | try?                                    |
| 4             | 23a d   | ra D          | 1712 Lorre Drive  |   |              |                                | 2085   | 2   |  | Unit                | ed S                    | tate                         | s                                       |
| 7             | tems  | Funeral       | 11. Marital Status  | 12. Was Decedent B<br>Armed Forces?                                 |              | S. 13.                         | Was Decedent of H                                  | lispanic Origin? (Span, Mexican, Puerto   | pecify Yes or No<br>Rican, etc.)         | -                   |                         | - Americ                     | an Indian,                              |
| ک<br>وی<br>آ  | natural", or items 23a or 28a-f show<br>Alcal Examiner must be restilled at   | by F          | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced                        | 1 ∐Yes 2 🛣N<br>If Yes, Give<br>Year or Dates:                       | lo           |                                | 1 □Yes 2⊠No  | Specify:                                  |  |                     | Specify:                |                              |   |
| 3-003b        | atura   |               | 15. Decedent's Ed   | lucation  |              | 16a. Dece                      | dent's Usual Occup                                 | pation                                    |  | 16b. Ki             | ind of Bus              |                              |   |
| Z Z           | ie.   | Completed     | (Specify only highest gra   | College (1-4or 5  | +)           | (Give<br>life.                 | kind of work done<br>DO NOT use retired<br>Directo | during most of world)<br>Tof Navy         | king<br>7                                |                     |                         |                              |   |
| 7             | lygier<br>her th<br>it, ir v  |               |   | 5+  |              | Public                         | ations &   | Printing                                  | 5  |                     |                         |                              | rnment                                  |
| and           | ntal F<br>ed otl  | Be            | 17. Father's Name (First, Middle, Last)                                       |   |              |                                |  | 18. Mother's Nam                          |  |                     | Surname                 | <del>?</del> )               |   |
| <b>X</b>      | mark  | ည             | Frank Zmuda  19a. Informant's Name/Relationship (3)                           | Type Print)   |              | 19h Mailir                     | ng Address (Street                                 |   |  |                     | r Tawa S                | Stata Zin                    | Cada                                    |
| Z 2           | alth ar<br>27 is<br>r trau  |               | Mary Susan Zmuda  |   |              |                                | Lorre Dr   |   |  | -                   |                         |                              | ,                                       |
| J'e,          | of He<br>of He<br>item  | 1             | 20a. Method of Disposition  |   | 20b. P       |                                | sition (Name of<br>natory or other place           |   |  |                     | ocation - 0             |                              |   |
|               | ment ant: If  |               | 1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify                  |   |              |                                | Crematorium  | 1 70                                      |  | Beth                | esda                    | , Man                        | ryland                                  |
| Daitimor      | permit. Tages rature associated being within 72 mous after beart with the may real permits of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be restlifted at once. |               | 21. Signature of Funeral Service Licen  | √_ )  | 10089        |                                |  |   |  |                     |                         |                              | 11e, Inc.<br>20850-2805                 |
|               |   |               | 23a. Part 1. Enter the disease, or comp<br>shock, or heart failure. List only | olications that caused  | the death    |                                |  |   |  |                     | ,                       | 1110                         | Approximate<br>Interval Between         |
| P             | hysician  |               | Immediate Cause (Fifth disease or condition                                   | Coronai   |              | tery I                         | )isease  |   |  |                     |                         | 1                            | Opset and Death<br>10 years             |
|               | /Medical<br>xaminer   |               | resulting in death)   | Due to (or as   | a consequ    | uence of):                     |  |   |  |                     |                         |                              | 10                                      |
|               | .xammet   | Į.            | Sequentially list conditions, if any, leading to immediate                    | b. Ischemi  |              |                                | opathy   |   |  |                     |                         |                              | 10 years                                |
| 7. 2          | T Insit   | Examiner      | Cause (Disease or injury  | Due to for as a   | CONSEQ       | ence on                        |  |   |  |                     |                         |                              |   |
| , ave         | an and<br>ial-tra   | Еха           | that initiated events<br>resulting in death) Last                             | Due to (or as   | a consequ    | uence of):                     |  |   |  |                     |                         |                              |   |
| ficate he ex  | hysicia<br>he bui   | edical        |   | d   |              |                                |  |   |  |                     |                         |                              |   |
| ortific.      | ling ph   |               | IF FEMALE:  |   |              |                                |  |   |  |                     |                         |                              |   |
| DOX           | attend<br>for us  | Physician/M   | 23b. Was decedent pregnant in the past 12 months?                             | 23c. If yes, outcome  | 2 Fetal      | Ideath 3                       | Ectopic pregnanc                                   | y   |  |                     | 23d. Date<br>Mon        |                              | ry<br>Day Year                          |
| 5             | y the   | ysic          | 1 □ Yes 2 □ No<br>9 □ Unknown   | 4 ☐ Pregnant at<br>9 ☐ Unknown                                      | time of d    | leath 5 L                      | Other (specify) _                                  |   |  |                     |                         |                              | 20,                                     |
| r ted         | ned b   |               | Part II. Other significant conditions of                                      | ontributing to death bu   | ıt not resu  | ulting in the u                | nderlying cause giv                                | en in Part I.                             | 23e. Did t                               | obacco u            | use contri              | bute to th                   | e cause of death?                       |
| necords,      | an sig  | ed by         | End Stage Renal D   | isease  |              |                                |  |   | 1 🗆 '                                    | Yes 2               | X No                    | 3 ☐ Prob                     | ably 4 Unknown                          |
|               | as ber<br>2 sho   | plet          |   |   |              |                                |  |   | 24a. Was                                 |                     | 24b. W                  | /ere auto                    | osy findings available                  |
| <b>1</b> 94   | ate ha  | Completed     |   | ·   |              |                                |  |   | autoj<br>perfo<br>1 □ Yes                | rmed?               | l de                    | rior to cor<br>eath?<br>□Yes | npletion of cause of<br>2 □ No          |
| VICIAN        | sertific<br>sctor,  | Be (          | 25. Was case referred to medical examiner?                                    |   |              |                                |  | 26. Place of Dea                          |  |                     | <u> </u>                |                              |   |
| 5 Physical    | this call dire  | 2             | 1 ☑ Yes 2 ☐ No  27. Manner of Death   |   |              | ER/Outpatier                   |  | 4 LI Nursing H                            | ome 5 🛛 Resi                             |                     |                         |                              | )                                       |
| i i           | h.<br>After<br>funer  | tion          | 1 XNatural 5 ☐ Pending  | 28a. Date of Inju<br>(Month, Day                                    | (, Year)     | 28b. Time of<br>Injury         | Wor  | yat<br>k?<br>Yes 2 □ No                   | 28d. Describe                            | how injur           | y occurre               | d                            |   |
| Affending Phy | r deat<br>sctor:<br>by the  | ertification: | 3 ☐ Suicide 6 ☐ Could not be  | 28e. Place of Inju  | ıry - At ho  | ome, farm, str                 |  | 163 2                                     | 28f. Location (                          | Street an           | id Numbe                | r or Rura                    | I Route Number,                         |
| 5 2           | s after   | Certi         | 4 ☐ Homicide determined   | building, etc   | :. (Specify  | y)                             |  |   | City or To                               | wn, State           | )                       |                              | , |
| Hosnit        | within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  | edical (      | 29a. Certifier 1 🔀 Certifying Ph<br>(Check only one) 2 Medical Exam           | ysician: To the best on<br>niner: On the basis of<br>and manner sta | examina      | wledge, deat<br>tion and/or in | h occurred at the tivestigation, in my o           | me, date and place<br>opinion, death occu | , and due to the<br>rred at the time,    | cause(s<br>date and | ) and mai<br>d place, a | nner as s<br>nd due to       | tated.<br>the cause(s)                  |
| To the        | within<br>To the  | Me            | 29b. Signature and title of certifier   | . 1   |              |                                | 29c. Licens  | e number                                  |  | 29d. Da             | te signed               | (Month,                      | Day, Year)                              |
|               |   |               | > / puel Ol   |   |              |                                | D2   | 1340                                      |  | May                 | 19,                     | 2008                         |   |
|               | 1/2   |               | 30. Name and address of person who a  |   |              |                                |  | #302 - Roy                                | ckville                                  | Mar                 | rv1ar                   | nd 20                        | 0850                                    |
|               | Sta   |               | 31. Date filed (Month, Day, Year)   |   |              | ture                           |  |   |  | ,                   | - 7 - 41                |                              |   |
|               | Registra  | ar            | MAY 282   | UUU AND SEE   | Wet o        | from the                       | ASTREAM  |   |  |                     |                         |                              |   |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ARTHUR Month 0041 M **Physician** VEL 4 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 93<sup>Yrs</sup> Aug. 19,1914 Washington, D.C. Director 577-03-1240 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3003 Lake Avenue 20785 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 【 No Specify: White ģ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Liquor Wholesaler Bookkeeper permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If item 27 Is marked other 1 any Injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( John William Glascoe, Sr. Mary Maude Tucker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Don Arthur / Son</u> 5846 Greenock Road Lothian, Maryland 20711 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 5-9-2008 5 Other (Specify) Edgewater, Maryland Kalas Crematory 4 Donation 21. Signatury Funara 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Interval Between Opset and Death ase or condition neu avoni Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknowr n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has rmed2 2/2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA Certification: To After this 27. Manper of Death funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident thours after death uneral Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier/ DEFENSE HGHWAY ANNAPRIS MARY Name and address of person who complete cause of death (Item 23a) (Type, Print) NTA W 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 0 9 2008 Registrar

08-03632 William Ralph Allen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| 7 | I VDC OI |                | don madi-     |             |       |           |          |
|---|----------|----------------|---------------|-------------|-------|-----------|----------|
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|   | Ctata of | Mandand /      | Department of | ot Healti   | า ลทก | wental    | rivalene |
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2008 17261

|  |  |                   | For State  |  | Certificate of Death   |   |                                      |                           |                                       |                                  |                   |   | g. No.   |                                    | 3. Time  | of Dooth  |
|--|--|-------------------|--|--|--|---|--------------------------------------|---------------------------|---------------------------------------|----------------------------------|-------------------|---|--|------------------------------------|--|---|
| Ph<br>edical E   | nysicia<br>Examir  | n/                | Decedent's Name (Fi<br>Willia  | rst, Middle,La<br>m Ra1  | 1ph Allen  |   |                                      |                           |                                       |                                  |                   | Date of Deat<br>Month<br>May 12, 2        | Day<br>008                                     | Year                               | 121  | 5 hrs   |
|  | )  |                   | a. Facility Name (if not<br>Prince George  |  |  | mber)   | 41                                   | b. City, Tow<br>Cheverl   |                                       | ocation of (                     |                   |   | Princ  | inty of De<br>ce Geo               | rge's  |   |
|  | neral<br>ector   |                   | 5. Social Security Numb  |  | Sex  | 7. Age (In yrs. last bir  | rthday)<br>Yrs.                      | If Under 1<br>Months      | Year<br>Days                          | If Under :<br>Hours              | 24Hrs.<br>Min.    |   | 14, 1  | IFo                                | Birthplace (S<br>reign<br>Country)                     | State or<br>TEXAS                                   |
| AD 21215-0036<br>2 should be filed within 72 hours after death with the Maryland | e.<br>than "natural", or items 23a or 28a-f show any<br>edical Examiner must be notified at once.  | Director          | MD  10e. Street and Numbe  57  11. Marital Status  1 Never Married   | P.G  P.G  O9 Ver  2 Marrie 4 XXDivorce ation (Specify  | 12. Was Der Armed F 1 XXYes If Yes, Give Ye or Dates: only highest gra | ar WWII   | 13. War If You and Deceden during mo | 10f. Zip Co               | of Hispo<br>Cuban,<br>No<br>ccupation | Mexican, is specify: on (Give ki | n? (Spec          | cify Yes or No<br>ican, etc.)             | 5- 14.   | Race - A<br>White, et              | 1 Country? States merican India tc. White ess/Industry |   |
| 21215-00;<br>Id be filed with  | 20a. Method of Disposition  1 Burial 2 XX Cremation 3 Removal from State  4 Donation 5 Other Specify:  21 So feature of Fund Service Licensee/  22. Name and Address Alexandri |                   |  |  |  |   |                                      |                           | 1                                     | Ju]                              | lie l             | First, Middle,<br>Koonce<br>ural Route Nu |  |                                    | State, Zip Co  | ode)  |
| Baltimore, MD 2  |  |                   |  |  |  |   |                                      |                           | May<br>May<br>Address                 | of Facility<br>Feri              | 200<br>ee<br>ry R | Date<br>8<br>Funera<br>oad, C             | Clin<br>1 Home<br>linton                       | ation - Ci<br>nton<br>e, I<br>n, M | , MD<br>nc 663<br>D 207                                | 3 Old   |
| V.   | sician<br>dical<br>iminer  |                   | 23a. Part I. Enter the c<br>failure. List only<br>Immediate Cause (Fir   | rart I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as canaliure. List only one cause on each line.  diate Cause (Final disease didition resulting in death)  Due to (or as a consequence of): |  |   |                                      |                           |                                       |                                  |                   |   | rrest, snock,                                  | , or neart                         | Beh  | ween Onset and<br>Death                             |
| paj  | nsit   | Examiner          | Sequentially list cond if any, leading to imm cause. Enter Underly (Disease or injury ina events resulting in de | ediate<br>ving Cause<br>เ เกเแลเed   | 0  | a consequence of):  |                                      |                           |                                       |                                  |                   |   |  |                                    |  |   |
| Box 68760,   | the attending physician and ed for use as the burial - transit   | Physician/Medical | X UNPENDED  IF FEMALE: 23b. Was decedent pr past 12 months?  1 Yes 2 No  | g Unkno  | 23c. If yes  23c. If yes  1 Live  4 Pre  9 Uni                         | 7,28a-f, rs, outcome of pregnand birth gnant at time of death       | 2 F                                  | etal death<br>Other (Spec | 3  <br>cify) _                        | Ectopie                          | c pregna          |   | М  | Date of d                          | Day  | Year use of death?                                  |
| cords, P.O.  | taw requires inat inc<br>has been signed by te<br>e 2 should be detache  | Completed by Pl   |  | cant conditio  | ns contributing  | g to death but not resu   | liting in the                        | underlying                | cause                                 | giveniii Fa                      |                   | 1'<br>24a. W<br>au<br>pe                  | Yes 2  | No 3                               | Probably<br>ere autopsy                                | 4 Unknown findings available ation of cause of 2 No |
| Vital Re   | tysician: The<br>this certificate<br>director, page  | o Be Cor          | 25. Was case referre examiner? 1 ✓ Yes 2   |  | Hospital:  |   | R/Outpatie                           | nt 3 D                    | OA                                    | Other                            | Nursir            | only one)                                 | Residen  |                                    | Other:   |   |
| Very standard of Death   1   1   1   1   1   1   1   1   1                       |  |                   |  |  |  |   |                                      | 00 am                     | 1 / office                            | late and p                       | No<br>etc.        | head 28f. Location or Tow 5709            | on (Street and no., State) Vernon cause(s) and | d Numbe<br>Way                     | er or Rural Ror Suit                                   | oute Number, City                                   |
|  | To the H within 24 To the Fi   | Medical           | 29b. Signature and t   | The state of examination and/or  |  |   |                                      |                           |                                       | se numbe                         | ccurred           | at the time, d                            | 29d. D   | e, and d                           | ed (Month, E   |   |
|  |  |                   | Donna M. Vi  | ncenti, MD   | Assistar   | cause of death (Item 2<br>at Medical Exami<br>Registrar's Signature | iner 1                               |                           |                                       | t, Baltin                        | nore, N           | MD 21201                                  |  |                                    |  |   |
|  | Reg  | State<br>istra    | PMT.   | AY 2 8   | 2008   | appear to   | A                                    | all o                     |                                       |                                  |                   |   |  |                                    |  |   |

OCME

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** <sup>Day</sup> 2008 Richard 8:00 A M Michael Biederman May 12, /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Rebecca House Potomac Montgomery Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 4, Birthplace (State or Foreign
Country) **Funeral** Days 1 M 2 □ F Hours 012-28-3818 Director 71 1937 Massachusetts Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene.
• other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location ıral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Montgomery Potomac 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 12100 Devilwood Drive 20854 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1X Yes 2 No If Yes, Give 1 Never Married Married Maryland 21215-0036 1 ☐ Yes 2 No þ Specify Specify:White 3 Widowed 4 Divorced Year or Dates:1956-67 Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Owner Dry Cleaning permit. Pages 1 and 2 should be file Department of Health and Mental Hinportant: If Item 27 Is marked oth any linjury or other traumatic evenions. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bernard Biederman Ann Sheff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12100 Devilwood Drive Potomac, MD 20854 Hetty K. Biederman/wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXX remation 3 ☐ Removal from State 05/13/08 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signata of Funeral Service Licen Coing Home Cremation Service P.O. Box 784 23a. Part1. Enter the Tsease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a Atherosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): Examiner b. Hypertension Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): that the death certificate be executed physician and s the burial-trans c. Anemia Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical ending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ as been signal 1 Tyes 2 00 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy page certificate 1∐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2D No 2 1 Inpatient 2 ER/Outpatient 3 DOA : After thi 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No n 24 hours after death.

ne Funeral Director: A

oletely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital or Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier one within 2 To the complet 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P D 41185 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vinu Ganti, M.D. 19529 Doctor's Drive Germantown, MD 20874 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 3 2008

State of Maryland / Department of Health and Mental Hygien 9 1 8 17263 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Month **Physician** May 09 2008 11:20a M Butler Lawrence /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Charles LaPlata Charles County Nursing & Rehab 8. Date of Birth (Month, Day, Year) 51 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1X M 2 ☐ F **Funeral** Min. Months Days Hours Yrs. Maryland 212-56-2410 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f ehow other treumetic event, the Medical Examiner - ust be natified at fX Yes 2 No Maryland
10e. Street and Num Charles Bryantown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5 USA 6340 Sunnybrook Place 20617 'netural', or Items 23a death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Item any injury or other treumetic event, the Medical Examination. 1 ☐ Yes 2 💆 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: Black à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Federal Government Building Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Greenfield Magdalen Oscar Butler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2,0772 19a. Informant's Name/Relationship (Type, Print) 7707 Georgian Dr. Upper Marlboro, Maryland Keisha Butler/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Mary's 5/16/08 Bryantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Juneral Service License 22. Name and Address of Facility Adams Funeral Home PA 20605 Aquasco Rd. Aquasco, Maryland 20608 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cance Priysician Lung disease or condition resulting in death) /Medical Due to (or ach consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit equires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decadent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No page 2 certificate To the Hospital or Attending Physician: 26. Place of Death (Check only one) in by the funeral director, 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 ☐ Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: 1 Natural 2 ☐ Accident 5 Pending 1 🔲 Yes 2 No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 - Homicide within 24 hours a To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie Suite 101 Camp Brings, Mary Jand 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5625 AllEN THIMA HUSSEIN 31. Date filed (Month, Day, Year) 32. Reistrar's Signature State MAY 1 3 2008 Registrar

|                            |  |                   | For State  | State of M                                     | aryland /                             | •                        | artment of F                           |  | Mental Hy                         |                          | 000                            | ^                             | 17061                      |
|----------------------------|--|-------------------|--|--|---------------------------------------|--------------------------|--|--|-----------------------------------|--------------------------|--------------------------------|-------------------------------|----------------------------|
|                            |  |                   | Registrar  1. Decedent's Name (First, Middle, L.   | aet)   |                                       | Cer                      | unicate of                             | Dealli                                 | 2. Date of De                     | Reg. No.                 | 200                            | $8_{\pm 3}$                   | Time of Death              |
| П                          | Physicia   | an                |  | ·  |                                       |                          |  |  | Month                             | Day                      |                                |                               | 5:17 A <sup>M</sup>        |
| and a                      | /Medic<br>Examin   | - 1               | Betty June Bedna:  |  |                                       |                          | 4b. City, Town, o                      | or Location of Dea                     | May 6,                            |                          | County of De                   |                               | J:17 A                     |
| 7                          | Examin   | ु                 | Anne Arundel Med   |  |                                       |                          | Annapol                                | is                                     |                                   | An                       | ne Aru                         | nde1                          |                            |
| -                          | Funeral  |                   | 5. Social Security Number 6.   | Sex 7. Ag                                      | ge (In yrs. last                      |                          | If Under 1 Year<br>Months Days         |  | (Month, D                         | av. Year)                |                                | irthplace<br>Co <i>untry)</i> | (State or Foreign          |
| Aug                        | Director   |                   | 465-52-9424  | 1 □ M 2 🔼 F                                    | 73                                    | Yrs.                     | - Dayo                                 | 770010                                 | July 2                            | 5, 19                    |                                | exas                          |                            |
|                            | and  |                   | Usual Residence of Decedent  10a. State 10b. Counfy  |  | 10c. City, To                         | own or Lo                | cation                                 |  |                                   |                          |                                | 10d. I                        | Inside City Limits         |
|                            | Marylan<br>f show<br>led at  | ō                 | Maryland Anne Ar   | undel  | Davi                                  | dean                     | ville                                  |  |                                   |                          |                                | 1                             | 1 □Yes 2 <b>X</b> No       |
|                            | r 28a-   | Director          | 10e. Street and Number   | macı   | Davi                                  | .45011                   | 10f. Zip Code                          |  |                                   | 10g. Citiz               | zen of What 0                  | L<br>Country?                 |                            |
|                            | h with   | al D              | 1551 Patuxent Ma   | nor Road                                       |                                       |                          | 21035                                  |  |                                   | 1                        | USA                            |                               |                            |
|                            | ems 2  | Funeral           | 11. Marital Status   | 12. Was Decedent<br>Armed Forces               | Ever in U.S.                          | 13.                      | Was Decedent of I                      | Hispanic Origin? (                     | Specify Yes or Nerto Rican, etc.) | 0-                       | 14. Race - An<br>Black, Wh     |                               | ndian,                     |
| 36                         | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Examiner must be notified at once.  | by Fu             | 1 ☐ Never Married 21⁄2 Married<br>3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☑<br>If Yes, Give<br>Year or Dates:  |                                       |                          | 1 □ Yes 2√√ No                         |  |                                   |                          |                                | Whit                          | e                          |
| 21215-0036                 | 72 hou<br>natura<br>Ical E   | ted               | 15. Decedent's l   | Education                                      | 11                                    |                          | dent's Usual Occu<br>kind of work done |  | orkina                            | 16b. Ki                  | nd of Busines                  | s/Industr                     | ry                         |
| 121                        | ne.<br>han "r<br>e Med   | Completed         | Elementary/Secondary (0-12)  | College (1-4or                                 |                                       | life.                    | DO NOT use retire                      | d)                                     | onung                             | 11                       |                                |                               |                            |
| 121                        | lled w<br>Hygiel<br>Iher ti  |                   | 12<br>17. Father's Name ( <i>First, Middle, Las</i>  |  | H                                     | lomem                    | aker                                   | 18. Mother's N                         | ame (First, Middle                |                          | OME<br>Surname)                |                               |                            |
| Maryland                   | d be f<br>ental h<br>ced ol  | Be c              | Carlos Ray Thomas  | ,  |                                       |                          |  |  | ess Lewi                          |                          | ,                              |                               |                            |
| Z                          | should not Me mark   | 은                 | 19a. Informant's Name/Relationship   |  | 1                                     | 9b. Mailir               | ng Address (Street                     |  |                                   |                          | r Town, State                  | , Zip Cod                     | de)                        |
|                            | and 2 alth a set rate  |                   | Charles E. Bedna   | rik, Sr./H                                     | usband                                | 1551                     | Patuxen                                | t Manor                                | Rd., Dav                          | ridso                    | nville                         | , MD                          | 21035                      |
| Baltimore,                 | ges 1 at of He   |                   | 20a. Method of Disposition  1 Burial 2 Cremation 3   | ☐Removal from State                            | ceme                                  | etery, crei              | sition (Name of matory or other pla    | ace)                                   | Date / 2008                       | ļ                        | ocation - City o               |                               |                            |
| ij                         | it. Pagintmen<br>rtant:<br>njury   |                   | 4 □ Donation 5 □ Other (Special Service Lice   |  | Lake                                  |                          | Cemeter                                |  | <u> </u>                          | ļ                        |                                |                               |                            |
| Bal                        | permii<br>Depar<br>Impor<br>any ir   |                   | 21. Signature of unitar service City   | hall   |                                       | 2                        | 2. Name and Address 973 So1o           | mons Isl                               | eorge P.<br>and Rd                | Edge                     | as Fun<br>water.               | eral<br>MD                    | Home<br>21037              |
|                            |  |                   | 28a. Part1 Enter the disease, or co<br>shock, or heart failure. List on                                      | mplications that cause                         | d the death. D                        |                          |  |  |                                   |                          | ,                              | Ap                            | proximate<br>erval Between |
|                            | Physician  | 0 3               | Immediate Cause (Final disease or condition  | lau of   | lagli                                 | 100                      | MAIA                                   |  |                                   |                          |                                | On                            | nset and Death             |
| 4                          | /Medical   |                   | resulting in death)  | a.<br>Due lo tir as                            | s a cons y uen                        | o of):                   | 200 (1.00                              |  |                                   |                          |                                |                               |                            |
|                            | Examiner   | L                 | Sequentially list conditions,  | b  |                                       |                          |  |  |                                   |                          |                                | 4                             |                            |
|                            | ed sit   | nine              | Sequentially list conditions, if any, leading to immediate cause Enter I to driving Cause (Disease or injury | Due to (or as                                  | s a consequen                         | ce or):                  |  |  |                                   |                          |                                |                               |                            |
|                            | ate be executed<br>hysician and<br>the burial-transit  | Examiner          | Cause (Disease or injury that initiated events resulting in death) Last                                      | c<br>Due to (or as                             | s a consequen                         | ce of):                  |  |  |                                   |                          |                                | -                             |                            |
| 8760,                      | e be (   | cal               |  | d  |                                       |                          |  |  |                                   |                          |                                |                               |                            |
| 9                          | tificate<br>ig phys<br>as the  | ledi              |  | # 5.0 Sec.                                     |                                       |                          |  |  |                                   |                          |                                | -                             | -                          |
| Box                        | death certific<br>e attending p<br>d for use as  | an/N              | 23b. Was decedent pregnant   | 23c. If yes, outcome<br>1 ☐ Live birth         |                                       |                          | ∃Ectopic pregnanc                      | су                                     |                                   |                          | 23d. Date of o                 | delivery<br>Day               | y Year                     |
| .O.                        | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as i  | Physician/Medical | in the past 12 months?<br>1 ☐ Yes 2 75 No<br>9 ☐ Unknown   | 4□Pregnant a<br>9□Unknown                      | at time of deat                       | h 5[                     | Other (specify)                        |  |                                   |                          | WOITH                          | Day                           | y icai                     |
| 0                          | The law requires that the tee has been signed by the bage 2 should be detache  |                   | Part II. Other significant conditions  | contributing to death                          | but not resultin                      | g in the u               | nderlying cause gi                     | ven in Part I.                         | 23e. Did                          | tobacco u                | use contribute                 | to the c                      | ause of death?             |
| ds,                        | uires<br>signe   | d by              |  |  |                                       |                          |  |  | 1 🗆                               | Yes 2                    | <b>⊠</b> (No 3□                | Probably                      | y 4 ∐Unknown               |
| 00                         | w req  | lete              |  |  |                                       |                          |  |  | 24a. Wa                           |                          | 24b. Were                      | autopsy                       | findings available         |
| Re                         | ician: The lav<br>certificate has<br>ector, page 2   | Completed         |  |  |                                       |                          |  |  | - aut<br>per<br>1□ Yes            | opsy<br>formed?<br>2 No  | prior t<br>death               | ?                             | etion of cause of          |
| ita                        | ian: Triffica  | Be C              | 25. Was case referred to medical   |  |                                       |                          | 620.0                                  | 26. Place of D                         | eath (Check only                  |                          | , , , , , ,                    | 03 2                          |                            |
| \ \                        | Physician:<br>r this certific<br>ral director,   | To E              | examiner?<br>1 ⊟ Yes 2 No  | Hospital: 1 ☐ Inpat                            | ient 202ER                            | /Outpatie                | " 0000                                 |  | Home 5□Res                        | sidence                  | 6 □Other (S                    | pecity)                       |                            |
| n o                        | ding PI<br>n.<br>After tl<br>funeral   | :uo               | 27. Manner of Death 1 ■ Natural 5 □ Pending  | 28a. Date of Inj<br>(Month, D                  |                                       | lb. Time o<br>Injury     | We                                     |  | 28d. Describe                     | how injur                | ry occurred                    |                               |                            |
| sio                        | Attending r death. ector: After by the fune  | cati              | 2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not   |  | ium. At homo                          | form of                  |  | ]Yes 2 ☐ No                            | OOL Legation                      | (Ctroot or               | nd Number or                   | Duml C                        | auta Mumbar                |
| Division or Vital Records, | il or Attend<br>after death.<br>I Director: /<br>d in by the f   | Certification:    | 4 ☐ Homicide determine   | d 28e. Place of it building, e                 | etc. (Specify)                        | i, iaiiii, Su            | reet, factory, office                  |  |                                   | own, State               |                                | nurai no                      | oute Number,               |
|                            | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page  | Medical C         | 29a. Certifier 1 CertifyIng I<br>(Check only one) 2 Medical Ex   | Physician: To the best<br>aminer: On the basis | of examination                        | dge, deat<br>n and/or ir | h occurred at the ovestigation, in my  | time, date and pla<br>opinion, death o | ace, and due to the               | e cause(s<br>e, date and | ) and manner<br>d place, and c | as state                      | d.<br>e cause(s)           |
|                            | To the To | Me                | 29b. Signature and line of certifier   | 11   |                                       |                          | 29c. Licen                             | se number                              |                                   |                          | ite signed (Mo                 |                               | /, Year)                   |
|                            |  |                   | Stock  | LIL  |                                       |                          | DS                                     | 8510                                   |                                   | 0.                       | 5/06                           | 0/0                           | 8                          |
|                            |  |                   | 30. Name and address of person wh  | no completed cause of                          | death (Item 23                        | Ba) (Type,               | Print)                                 | 444                                    | J                                 |                          |                                | -                             |                            |
|                            | W 15   |                   | Heplum   | ( ( X ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )        | trar's Signature                      | D                        | A de                                   | MIC                                    |                                   |                          |                                |                               |                            |
|                            | Sta<br>Regist  |                   | 31. Date filed (Month, Day, Year)  | 2008   | w b                                   | ?                        | Carrie .                               |  |                                   |                          |                                |                               |                            |
| DH                         | IMH 17 Rev 1/2   |                   |  |  | , , , , , , , , , , , , , , , , , , , | -19                      |  |  |                                   |                          |                                |                               |                            |

|                |   |                | 1 - For<br>State<br>Registrar   | State of Maryla   | nd / Depa<br><i>Cer</i> i     | rtment of H<br>tificate of I                | lealth and M<br>Death                         | ental Hygio<br>Req                   | ene<br>g. No. <b>200</b> 8       | 17265  |
|----------------|---|----------------|---|---|-------------------------------|---|---|--------------------------------------|----------------------------------|--|
| V              | Dhusisi   |                | 1. Decedent's Name (First, Middle, Last   | )   |                               |   |   | 2. Date of Death<br>Month            | Day Year                         | 3. Time of Death                                   |
|                | Physici<br>/Medio   |                | RAYMOND   |   | BROW                          |   | R   | 5                                    | 12 2008                          | 1010 AM  |
|                | Examin<br>Funeral   | ier            | 5. Social Security Number 6. Se   | x + the Lak   | e. e. s. last birthday)       | Salis<br>If Under 1 Year                    |   | 8. Date of Birth (Month, Day,        | 9 Birth                          | polace (State or Foreign                           |
|                | Director  |                | 213 24 8327   | M 2 F 78  | Yrs.                          | Months Days                                 | Hours Min.                                    | JUNG 21                              |                                  | UN.  |
|                | w w   |                | Usual Residence of Decedent  10a. State 10b. County                                     | 10c. C  | ity, Town or Loc              | ation                                       |   |                                      |                                  | 10d. Inside City Limits                            |
|                | Maryla<br>f sho   | ō              | VIRGINIA ACCOMAC  |   | INCOTE                        |   |   |                                      |                                  | 1 NYes 2 No  |
|                | r 28a-<br>notif   | Director       | 10e. Street and Number  | e Cn  | 1100161                       | 10f. Zip Code                               |   | 10                                   | g. Citizen of What Co            | untry?   |
|                | h with  | a D            | 6385 VACATION   | PARK LAN  | 16                            | 23336                                       |   |                                      | USA                              |  |
|                | ems<br>er mu  | Funeral        | 11. Marital Status  | 12. Was Decedent Ever in larged Forces?   | U.S. 13. W                    |   | ispanic Origin? (Spe<br>an, Mexican, Puerto I | cify Yes or No-<br>Rican, etc.)      | 14. Race - Amer<br>Black, White  |  |
| 96,00          | be filed within 72 hours after death with the Maryland<br>Ital Hygiene.<br>ed other than "natural", or items 23a or 28a-f show<br>event, the Medical Examiner must be notitled at | by             | 1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced                                  | 1 ⊠Yes 2 □ No<br>If Yes, Give<br>Year or Dates:   | 1                             | □Yes 2 <b>M</b> No                          | Specify:                                      |                                      | Specify: WA                      | 176  |
| 370            | "natu   | lete           | 15. Decedent's Edu<br>(Specify only highest grad  | cation<br>le completed)   | 16a. Decede                   | ent's Usual Occup<br>and of work done of    | ation<br>during most of workir<br>t)          | ng 1                                 | 6b. Kind of Business/            | Industry   |
| 12/2           | filed withir<br>Hygiene.<br>other than<br>ent, the Me   | Completed      | Elementary/Secondary (0-12)   | College (1-4or 5+)  | M/55/                         |   | NNICIAN                                       |                                      | PERUSPICO                        | = INDUSTRY   |
| 2              | 2 should be filed withir<br>and Mental Hygiene.<br>Is marked other than<br>aumatic event, the Me  | Be Co          | 17. Father's Name (First, Middle, Last)   | 77.13   | 1 • • • •                     |   | 18. Mother's Name                             |                                      |                                  | 77.000777,9  |
| <u>a</u>       | ould be a<br>Mental arked o   | To B           | RAYMOND HENL  | CY BROWN  | V SR                          |   | MYRET   | TA                                   | BOWER                            |  |
| Maryland       | 2 should the and Meni Is marked aumatic e   | . 8            | 19a. Informant's Name/Relationship (T)  | vpe. Print)   | 19b. Mailing                  | Address (Street                             | and Number or Rura                            | Route Number,                        | City or Town, State, 2<br>マタロ    | Zip Code)  |
| 305            | s 1 and 2 should<br>f Health and Mer<br>Item 27 Is marke<br>other traumatic   |                | NANCY ELLEN BROW  |   | Place of Dispos               | VACATION                                    | PARK DE                                       | IVE CHI                              | VCOTEREUE                        | UN 23336   |
| timore,        | ages 1 ar<br>nt of Hea<br>: If Item ;<br>or other   |                | 1 ☐ Burial 2 ☐ Cremation 3 ☐ F  | Removal from State  | cemetery, crem                | atory or other plac                         | ce)   |                                      | 0c. Location - City or           |  |
| 狺              | permit. Pages 1<br>Department of H<br>Important: If Ite<br>any Injury or ot<br>once.  |                | 4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens               |   |                               |   |   |                                      | WINCETERGUE<br>V FUNGRAL         | UA. 23336  |
| Baj            | permii<br>Depar<br>Impor<br>any Ir  |                | M. All yes  |   | 50                            | 44 CHICK                                    | CN CITY R                                     | end CHI                              | NCETERGUE,                       | VA. 23336  |
|                |   |                | 23a. Part1. Enter the disease, or comp shock, or heart failure. List only o             |   |                               |   |   |                                      | st,                              | Approximate<br>Interval Between<br>Onset and Death |
|                | Physician /Medical  |                | Immediate Cause (Final disease or condition resulting in death)                         | a. MR. TASTA<br>Due to (or as a conse   |                               | ASTRIC                                      | CARCIA  | ona                                  |                                  |  |
|                | Examiner  |                |   | h   | squerioe ory.                 |   |   |                                      |                                  |  |
|                | D #   | iner           | Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury          | Due to (or as a conse   | uence of):                    |   |   |                                      |                                  |  |
|                | ficate be executed<br>physician and<br>s the burial-transit   | Examiner       | Cause (Disease or injury that initiated events resulting in death) Last                 | c<br>Due to (or as a conse  | editence of).                 |   |   |                                      |                                  | · · · · · · · · · · · · · · · · · · ·              |
| 68760,         | be ey   | al E           |   |   | squence on.                   |   |   |                                      |                                  |  |
| 687            |   | edical         |   | 3.  |                               |   |   |                                      |                                  |  |
| P.O. Box       | Physician: The law requires that the death certific: this certificate has been signed by the attending plial director, page 2 should be detached for use as I                     | Physician/M    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf preg<br>1 □ Live birth 2 □ Fe<br>4 □ Pregnant at time of<br>9 □ Unknown | ital death 3□                 | Ectopic pregnancy<br>Other <i>(specify)</i> | ,   |                                      | 23d. Date of del<br>Month        | ivery<br>Day Year                                  |
|                | res that the de<br>signed by the a<br>be detached i   | by Ph          | Part II. Other significant conditions co  | ntributing to death but not re  | esulting in the un            | derlying cause giv                          | en in Part I.                                 | 23e. Did toba                        | acco use contribute to           | the cause of death?                                |
| Vital Records, | w require<br>been sig<br>should be  |                |   |   |                               |   |   | 1 ☐ Yes                              | s 2/⊡No 3 □ Pr                   | obably 4 Unknown                                   |
| ဝ၁             | ne law requ<br>has been<br>ge 2 shoulk  | Completed      |   |   |                               |   |   | 24a. Was an                          | 24b. Were au                     | utopsy findings available completion of cause of   |
| <u>=</u>       | The page  | Com            |   |   |                               |   |   | perform<br>1□ Yes                    | death?<br>☐No 1☐Yes              | -3   |
| Vita           | sician: The<br>certificate har<br>rector, page  | Be             | 25. Was case referred to medical examiner?  | Hospital:   |                               | 3□ DOA Oth                                  | 26. Place of Death                            |                                      |                                  |  |
| 0              | Phys<br>this<br>al dir  | . To           | 1 ☐ Yes 2 ☐ No  27. Mapmer of Death   | 28a. Date of Injury   | ER/Outpatient<br>28b. Time of | 3 DOA                                       | 4   Nursing Hor                               | ne 5 🗆 Resider<br>28d. Describe hov  | nce 6 Other (Spe                 | cify)  |
| on             | Attending it death. ector: After by the fune  | tion           | Natural 5 Pending 2 Accident investigation  | (Month, Day Year)   | Injury                        | 28c. Injur<br>Wor<br>M 1 🗆                  | k?<br>Yes 2 □ No                              |                                      | ,,                               |  |
| Division       | To the Hospital or Attending P within 24 hours at er death.  To the Funeral Director: After completely filled in by the fune?   | Certification: | 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of injury - At building, etc. (Spec  | home, farm, stre              | et, factory, office                         | 4   | 28f. Location (Str.<br>City or Town, | eet and Number or Ri<br>, State) | ural Route Number,                                 |
|                | e Hospita<br>24 hours<br>e Funeral  | Medical C      |   | /sician: To the best of my ki<br>iner: On the basis of examinand manner stated.                 |                               |   |   |                                      |                                  |  |
|                | To th<br>within<br>To th<br>comp  | Me             | 29b. Signature and title of certifier   |   |                               | 29c. Licens                                 |   |                                      | d. Date signed (Mont             | •  |
|                |   |                | X   |   |                               | Do  | 058410  | ,                                    | 5/12/0                           | 7  |
| ^              | 1.0.1   |                | 30. Name and ddress of person who c   |   |                               | Print)                                      | _   | . (2                                 | 1                                | B 21802  |
| B              | A 10+1  |                | 31. Date filed (Month, Day, Year)   | ONSTAL HO   | SPICE                         | 6.0 PSU                                     | × # 17  | ss saz                               | issuryu                          | 4021802  |
|                | Sta<br>Registi  |                | MAY 1 4 20  | 32. Registrar's Sig   | K A                           | sole)                                       |   |                                      |                                  |  |

State of Maryland / Department of Health and Mental Hygiene 2008

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|  |  | **             | State Registrar  |   | Cer                     | tificate of                                    | Death                                    | Re                                    | eg. No.                      | 0 17200   |
|--|--|----------------|--|---|-------------------------|--|--|---------------------------------------|------------------------------|---|
| ľ                                      |  |                | 1. Decedent's Name (First, Middle, Last)   |   |                         |  |  | 2. Date of Deat<br>Month              | th<br>Day Ye                 | 3. Time of Death  |
| 34                                     | Physici<br>/Medic  |                | Marguerite Eva Blocher   |   |                         |  |  |                                       | lay 19, 2008                 | 03:30 PM <sup>M</sup>                                     |
|  | Examin   | _              | 4a. Facility Name (If not institution, give s                                      | treet and number)   |                         | 4b. City, Town, o                              | r Location of Deat                       | h                                     | 4c. County of D              |   |
| 11 11 11 11 11 11 11 11 11 11 11 11 11 | All the second second  |                | 18 High Street   |   |                         | If I leader of Manual                          | Frostburg                                | D. D. J C. Dist.                      | Allegany                     |   |
|  | Funeral  |                | 5. Social Security Number 6. Sex   | M ONE   | last birthday)<br>Yrs.  | If Under 1 Year Months Days                    | If Under 24 Hrs<br>Hours Min.            | (Month, Day,                          |                              | Birthplace (State or Foreign<br>Country)                  |
| i.                                     | Director   |                | 214-36-6811 Usual Residence of Decedent  | 88  |                         |  |  | Januar                                | y 29, 1920                   | Maryland  |
|  | land<br>ow   |                | 10a. State 10b. County   | 10c. Ci   | ity, Town or Lo         | cation   |  |                                       |                              | 10d. Inside City Limits                                   |
|  | Mary<br>fied a   | ţō             | Maryland Allegany  | , Fr  | rostburg                |  |  |                                       |                              | 1 X Yes 2 □ No  |
|  | r 28a  | Director       | 10e. Street and Number 18 High S   |   |                         | 10f. Zip Code                                  |  | 1                                     | 0g. Citizen of What          | t Country?  |
|  | h with   |                | TOTIIGHT   | door  |                         | 21532-   |  |                                       | U.S.A.                       |   |
|  | deat<br>sms  | Funeral        | 11. Marital Status   | 2. Was Decedent Ever in U<br>Armed Forces?                  | J.S. 13.                | Was Decedent of H                              | lispanic Origin? (S<br>an, Mexican, Puer | Specify Yes or No-<br>to Rican, etc.) |                              | American Indian,<br>Vhite, etc.                           |
| 9                                      | d within 72 hours after death with the Maryland jiene.<br>r than "natural", or items 23a or 28a-f show than Medical Examiner must be notified at the Medical Examiner must be notified at  |                | 1 Never Married 2 Married  | 1 ☐ Yes 2 No<br>If Yes, Give                                |                         | 1 □ Yes 2 🕱 No                                 | Specify:                                 |                                       | Specify:                     |   |
| 8                                      | ural",   | d by           | 3 Widowed 4 □ Divorced   | Year or Dates:  | 16a Dagg                | f<br>dent's Usual Occup                        | nation                                   |                                       | 16b. Kind of Busine          | White   |
| 21215-0036                             | "nat   | Completed      | 15. Decedent's Educ<br>(Specify only highest grade                                 | completed)  | (Give                   | kind of work done DO NOT use retire            | during most of wo                        | rking                                 | Tob. Killa of Dasilie        | ess/industry  |
| 12                                     | filed within<br>Hygiene.<br>other than '<br>ent, the Me  | 崩              | Elementary/Secondary (0-12)  | College (1-4or 5+)  |                         | keeping  | ,  |                                       | state univer                 | sitv  |
|  | # # F  |                | 17. Father's Name (First, Middle, Last)  |   |                         |  | 18. Mother's Na                          | me (First, Middle, i                  |                              |   |
| an                                     | be de de de de de de de de de de de de de  | To Be          | Charles Chaney   |   |                         |  | Linnie L                                 | ayman                                 |                              |   |
| Maryland                               | 2 should by<br>and Menta<br>is marked<br>aumatic ev  | -              | 19a. Informant's Name/Relationship (Ty)  | pe. Print)  | 19b. Mailir             | ng Address (Street                             | and Number or R                          | ural Route Numbe                      | r, City or Town, Sta         | te, Zip Code)   |
|  | rt 2 mg  |                | Sandra Monahan   | daughter  | 10610                   | Cool Spring                                    | Lane Fr                                  | ostburg                               | Marylar                      | nd 21532-   |
| altimore,                              | of Hear<br>item  |                | 20a. Method of Disposition   |   | Place of Dispo          | sition (Name of<br>matory or other pla         | ce)                                      | Date                                  | 20c. Location - City         | or Town, State  |
| m                                      | Pages<br>nent of I<br>int: If Its  |                | 1 Burial 2 □ Cremation 3 □ R<br>4 □ Donation 5 □ Other (Specify)                   | emoval from State   | Frostburg               | Memorial Par                                   | rk I                                     | May 22, 2008                          | Frostburg                    | Maryland  |
| alti                                   | permit. Pag<br>Department<br>Important: I<br>any injury o  |                | 21. Signature of Funeral Service Licens  |   | . 22                    | 2. Name and Addre                              | ess of Facility                          |                                       |                              |   |
| m                                      | o a la   |                | John The   | Kerret  |                         |  |  |                                       | Frostburg, M                 | ID 21532  |
| Е                                      |  |                | 23a. Part1. Enter the disease, or compli-<br>shock, or heart failure. List only or | cations that caused the dea<br>ne cause on each line.       | th. Do not ent          | er the mode of dyi                             | ng, such as cardia                       | c or respiratory arr                  | rest,                        | Approximate<br>Interval Between                           |
|  | Physician  | r i            | Immediate Cause (Final disease or condition  | rectal  | Can                     | cer  |  |                                       |                              | Onset and Death   |
| 7                                      | /Medical   |                | resulting in death)  | Due to (or as a conse                                       | quence of):             |  |  |                                       |                              |   |
| 8                                      | Examiner   |                | Sequentially list conditions,  |   |                         |  |  |                                       |                              |   |
|  | pe tis   | ine            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury      | Due to (or as a conse                                       | quence of):             |  |  |                                       |                              |   |
|  | and I-tran   | Examine        | that initiated events resulting in death) Last                                     | Due to (or as a conse                                       | quence of):             |  |  |                                       |                              |   |
| 60,                                    | be ey<br>ician<br>buria  |                |  | 200 10 (01 00 00 00 00                                      | 4                       |  |  |                                       |                              |   |
| 68760,                                 | tificate be executed<br>ig physician and<br>as the burial-transit  | Medical        |  |   |                         |  |  |                                       |                              |   |
| ×                                      | certifi<br>nding<br>ise as   | -              | IF FEMALE:<br>23b. Was decedent pregnant   | 3c. If yes, outcome pf pregr                                |                         |  |  |                                       | 23d. Date o                  | f delivery  |
| Bo                                     | death cert<br>attending  | Physician      | in the past 12 months? 1 ☐ Yes 2 📉 No  | 1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of           |                         | ∃Ectopic pregnand<br>∃Other <i>(specify)</i> _ | у  |                                       | Month                        | · ·   |
| o.                                     | res that the de<br>signed by the<br>be detached  | hysi           | 9 🗆 Unknown  | 9□ Unknown  |                         |  |  |                                       |                              |   |
| ٠ <u>,</u>                             | s that<br>ned b  |                | Part II. Other significant conditions con  | ntributing to death but not re                              | sulting in the u        | nderlying cause gi                             | ven in Part I.                           | 23e. Did to                           | bacco use contribu           | ite to the cause of death?                                |
| ğ                                      | w require<br>been sig<br>should b  | Completed by   |  |   |                         |  |  | 1 🗆 Y                                 | 'es 2□No 3[                  | Probably 4 Unknown  |
| Vital Records,                         | aw re<br>s bec<br>2 sho  | olet           |  |   |                         |  |  | 24a. Was a                            |                              | re autopsy findings available r to completion of cause of |
| m                                      | The lav  | m o            |  |   |                         |  |  | perfor                                | med? dea                     |   |
| ita                                    | iysiclan: The iis certificate hadirector, page   | Be C           | 25. Was case referred to medical examiner?   |   |                         |  | 26. Place of De                          | ath (Check only or                    |                              |   |
| _ <                                    | hysic<br>this ce<br>al direc   | To             | 1 Yes 2 No   | lospital: 1 ☐ Inpatient 2 [                                 | ☐ ER/Outpatie           | IL SELDON                                      |  | Home 5 Resid                          | ence 6 Other                 | (Specify)   |
| Division or                            | ding Ph<br>h.<br>After th<br>funeral   |                | 27. Manner of Death 1 Natural 5 ☐ Pending  | 28a. Date of Injury<br>(Month, Day Year)                    | 28b. Time of Injury     | of 28c. Inju                                   | ıry at<br>ork?                           | 28d. Describe h                       | ow injury occurred           |   |
| 010                                    | endil<br>eath.<br>or: A  | Certification: | 2 ☐ Accident investigation   |   |                         |  | Yes 2 No                                 |                                       |                              |   |
| Ë                                      | or Att   | Ę              | 3 Suicide 6 Could not be 4 Homicide determined                                     | 28e. Place of injury - At I<br>building, etc. (Spec         | home, farm, st<br>cify) | reet, factory, office                          |  | 28f. Location (S<br>City or Tow       | itreet and Number on, State) | or Rural Route Number,                                    |
| Ω                                      | oital ours af  |                | 00 - Cadifica - 1 November - 1 November - 1  | alalan. To the best of my ke                                | nawladza dagi           | th occurred at the                             | time, data and play                      | a and due to the                      | cours(s) and mann            | or as stated  |
|  | Hosp<br>24 hou<br>Fune<br>fely f   | ical           |  | sician: To the best of my kr<br>ner: On the basis of examin |                         |  |  |                                       |                              |   |
|  | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit | Medical        | 29b. Signature and title of certifier  | and manner stated.  |                         |  | se number                                |                                       | 29d. Date signed (f          | Month, Day, Year)   |
|  | M Vi   |                | > wormoch.   | Eli MI  | 0                       | 000  | 55325                                    | -                                     |                              |   |
|  | 3  |                | 30. Name and address of person who co  |   | am 23a) (Tuno           | Print)   | 55325                                    |                                       | I way 2                      | 0,2008  |
|  | NLS  |                | WONSOCK SHIN   |   | 3ISHOP                  | WALSH  | RD CU                                    | MBERLAN                               | 10 MD 2                      | 1502  |
|  | _  | ate            | 31 Date filed (Month Day Year)   | 32. Redistrar's Sign  | nature                  | 1  |  | - 11                                  |                              |   |
|  | Regist   |                | MAY 212  | 008   | J.                      | gove   |  |                                       |                              |   |

State of Maryland / Department of Health and Mental Hygiene 2 6 9 9

|                  |  |   | 1 - State<br>Registrar   |                                    |                          |  |                               | Cert                | tificat               | e of L                                  | Death                      |                           |                                  | Reg. No.                 | 2000                          | 5                            | 1/20   | ı |
|------------------|--|---|--|------------------------------------|--------------------------|--|-------------------------------|---------------------|-----------------------|---|----------------------------|---------------------------|----------------------------------|--------------------------|-------------------------------|------------------------------|--|---|
|                  | Physici  | 1. Decedent's Name (First, Middle, Last)  James Patrick Barry |  |                                    |                          |  |                               |                     |                       |   |                            | 2. Date of De Month       |                                  | 08 Year                  |                               | Time of Death                | 1  |   |
|                  | /Medio   |   | 4a. Facility Name (If not i  | _                                  |                          |  |                               |                     | _                     | Town, or                                | Location o                 |                           |                                  | 4c.                      | County of Dea                 |                              |  | _ |
| 5 .              | Funeral<br>Director  | 1   | 5. Social Security Number 199–22–540   | 08 12                              | X<br>ZM 2□F              | 7. Age (                               | In yrs. last birt             | hday)<br>Yrs.       | If Unde<br>Months     | r 1 Year<br>Days                        | If Under<br>Hours          |                           | 8. Date of Bit (Month, Di        | †h<br>1926               | 9. Bi                         | rthplace<br>country)<br>I YO | (State or Foreigi                            | n |
|                  | and  |   | Usual Residence of Dece<br>10a. State 10b  | . County                           |                          | 1                                      | 0c. City, Town                | or Loc              | ation                 |   |                            |                           |                                  |                          |                               | 10d. I                       | nside City Limits                            | - |
|                  | d within 72 hours after death with the Maryland<br>gene.<br>r than "natural", or items 23a or 28a-f show<br>the Medical Examiner must be notified at | ector   |  | lvert                              |                          |  | Solomo                        | ns                  | 405 77                | 0-4-                                    |                            |                           |                                  | 40- Oili                 | of What O                     | <u> </u>                     | 1 □ Yes 2X No                                | ) |
|                  | th with t  | Funeral Director  | 10e. Street and Number   | ell Road                           | d                        |  |                               |                     | 206                   | Code<br>88                              |                            |                           |                                  |                          | zen of What C<br>ted Sta      |                              |  |   |
| ۵                | after des<br>or items<br>niner m   |   | 11. Marital Status 1 ☐ Never Married   | 2□ Married                         | 12. Was Dec<br>Armed Fo  | orces?<br>2 □ No                       |                               | 1                   |                       |   |                            | gin? (Spe<br>n, Puerto I  | city Yes or No<br>Rican, etc.)   | )-                       | 14. Race - Am<br>Black, Wh    | ite, etc.                    |  |   |
| 25               | ours a   | d by  | 3 ☐ Widowed 4 💢 I  | Divorced                           | If Yes, Gi<br>Year or D  | ve                                     | 1946                          | 1                   | Yes                   | 2 <b>A</b> J NO                         | Specify:                   |                           |                                  |                          | Specify: W                    | hite                         | <u> </u>                                     |   |
| 215-0036         | "natu  | lete  | 15. I<br>(Specify or   | Decedent's Edu<br>Ny highest grad  | ication<br>le completed) |  | 16a.                          | (Give k             | and of wa             | ial Occupa<br>ork done d<br>ise retired | lurina mos                 | t of workir               | ng                               | 16b. Kir                 | nd of Busines:                | s/Industr                    | у  |   |
| 7                | filed within 72<br>Hygiene.<br>other than "na<br>ent, the Medic  | Completed   | Elementary/Secondary   |                                    | College (<br>5+          | 1-4or 5+)                              | Ма                            | mag                 |                       | ise retired                             |                            |                           |                                  |                          | mical I                       | ndu                          | stry   |   |
| yland            | Φ 🚾 🗢  | To Be   | James Jose   | eph Bar                            |                          |  |                               |                     |                       |   | Alic                       | e Bu                      |                                  |                          |                               |                              |  |   |
| , Mar            | Pages 1 and 2 should be ment of Health and Ment ant: If item 27 is marked lury or other traumatic e  |   | 19a. Informant's Name/F  | ssler (1                           |                          | er)                                    | 12                            | 2015                | Cen                   | tury                                    | Mano                       | r Dr                      | ive, D                           | unkir                    | r Town, State,                | 207                          | 54   |   |
| Baltimore,       | Pages 1<br>nent of H<br>int: If iter   |   | 20a. Method of Disposition 1 ☐ Burial 2 🌠 Cre 4 ☐ Donation 5 ☐   | emation 3 🗆 F                      |                          | State                                  | 20b. Place of cemeter. Metrop |                     |                       |   |                            |                           | ate<br>2/2008                    |                          | cation - City o<br>xandria    |                              | State<br>irginia                             |   |
| Balt             | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.   |   | 21. Signature of Funeral   | Service Licens                     | see .                    |  |                               |                     |                       |   | s of Facilit               |                           |                                  |                          | ral Hon                       |                              | P.A.<br>d 20736                              |   |
| F                | E B  |   | 23a. Part1. Enter the dis  | sease, or complure. List only o    | ne cause on              | each line.                             |                               | ot ente             | r the mo              | de of dyin                              | g, such as                 |                           |                                  |                          | -, -,,                        | App                          | proximate<br>erval Between<br>set and Death  | _ |
| j.               | Physician<br>/Medical  |   | Immediate Cause (Final disease or condition resulting in death)  |                                    |                          |  | Onsequence of                 |                     | /EUN                  | LONIF                                   | 9                          | <del></del>               |                                  |                          |                               |                              |  |   |
| 27               | Examiner   | ler   | Sequentially list condition if any, leading to immedicause. Enter Underlying                             | ns,<br>ate                         | b. CV                    | (or as a d                             | consequence o                 | of):                |                       |   |                            |                           |                                  |                          |                               |                              |  |   |
|                  | xecuted<br>and<br>Il-transit   | Examin  | Cause. Enter Underlying<br>Cause (Disease or injury<br>that initiated events<br>resulting in death) Last | 1                                  | c                        | (or as a o                             | consequence of                | of):                |                       |   |                            |                           |                                  |                          |                               |                              |  | _ |
| <b>68/60</b> ,   | certificate be executed rding physician and ise as the burial-transit  | Medical E   |  |                                    | d                        |  |                               |                     |                       |   |                            |                           |                                  |                          |                               |                              |  | _ |
| ×                | certific<br>nding p  |   | IF FEMALE:<br>23b. Was decedent preg   | inant 4                            | 23c. If yes, ou          | tcome pf                               | pregnancy                     |                     |                       |   |                            |                           |                                  | 2                        | 23d. Date of de               | elivery                      |  | _ |
| O. BO            | that the death certificate be executed ed by the attending physician and detached for use as the burial-transit                                      | Physician   | in the past 12 mont 1 Yes 2 No 9 Unknown   |                                    |                          | nant at tir                            | Fetal death<br>ne of death    |                     | Ectopic p<br>Other (s | regnancy<br>pecify)                     |                            |                           |                                  |                          | Month                         | Day                          | Year   |   |
| S,               | law requires that the<br>as been signed by the<br>2 should be detache  | þ   | Part II. Other significant   | . 11 11                            |                          | eath but                               | not resulting in              | the un              | derlying              | cause give                              | en in Part I               |                           |                                  |                          |                               |                              | ause of death?                               |   |
| Hecord           | w requires<br>been signe<br>should be  | eted  | ATMAI TIDI   | 711101110                          | 2/1                      |  |                               |                     |                       | · .                                     |                            |                           | 24a. Was                         |                          |                               | robably                      |  |   |
|                  | The ate his page   | Completed   |  |                                    |                          |  |                               |                     |                       |   |                            |                           | auto                             |                          | death?                        | comple<br>s 2                | findings available<br>tion of cause of<br>No | 3 |
| VITal            | Physician:<br>this certific<br>ral director,   | Be  | 25. Was case referred to examiner?   |                                    | Hospital:                |  |                               |                     |                       | Out                                     |                            |                           | (Check only                      |                          |                               |                              |  | _ |
| 0                | Phy<br>this<br>al di   | . To  | 1 ☐ Yes 2 No<br>27. Manner of Death  |                                    | 28a. Date                |  | 2 ER/Out                      | tpatient<br>ime of  |                       |   | 9                          |                           | me 5 ☐ Res<br>28d. Describe      |                          | 6 □Other (Sp                  | ecify)                       |  | _ |
| UNISION          | tending<br>eath.<br>tor: Afte<br>the fune  | cation  | Natural 5 [<br>2 ☐ Accident  | Pending investigation Could not be | (Mor                     | nth, Day Y                             | /ear) Ir                      | njury               | М                     |   | k?<br>Yes 2□               | No                        |                                  |                          |                               |                              |  |   |
|                  | ipital or Attenions after deathers after deatheral Director:   | Certification:  | 4 ☐ Homicide   | determined                         | 28e. Place<br>build      | e of injury<br>ling, etc.              | - At home, far<br>(Specify)   | rm, stre            | et, factor            | y, office                               |                            | 2                         | 28f. Location (<br>City or To    | Street and<br>wn, State, | d Number or F<br>)            | Rural Ro                     | ute Number,                                  |   |
|                  | 24 hos<br>24 hos<br>Fur<br>etely   | Medical   | 29a. Certifier 1<br>(Check only 2<br>one)  | Certifying Phy<br>Medical Exam     | iner: On the b           | e best of e<br>pasis of e<br>ner state | xamination and                | , death<br>d/or inv | occurred              | at the tin<br>n, in my o                | ne, date ar<br>pinion, dea | nd place, a<br>ath occurr | and due to the<br>ed at the time | cause(s)<br>, date and   | and manner a<br>place, and du | as stated<br>ue to the       | f.<br>cause(s)                               |   |
| }                | To the within To the comple  | Ň   | 29b. Signature and title   | of certifier                       | - 11 X                   |  |                               |                     | 29                    | c. License                              | number 571                 | 2                         |                                  |                          | 12, 20                        |                              | Year)  |   |
| יוו <sup>י</sup> | 1 11   |   | 30. Name and address of Gwyneth A.   | f person who c                     | ompleted cause           | se of dea                              | th (Item 23a) (               | Type, F             | Print)<br>IS IS       | land                                    | Rd.,                       | Sol                       | omons,                           | Mary                     | yland 2                       | 2068                         | B  | _ |
| , v              | Sta  |   | 31. Date filed (Month, Da  | ay, Year)                          | · 32. F                  | Registrar                              | Signature                     |                     |                       |   |                            |                           |                                  |                          |                               |                              |  | _ |
| DIL              | Registr  | αI  |  | WIAT I                             | o 4000                   | ,Ca                                    | MEN.                          | 15                  | 190                   | West of                                 |                            |                           |                                  |                          |                               |                              |  | _ |

DHMH 17 Rev 1/2001

|                |  |                | For<br>State<br>Registrar   | State of M   | aryland / Depa   | artment<br>r <i>tificate</i>        |                        |                                      | Mer           |  |                      | 2008                         | 3                     | 172                                     | 268           |
|----------------|--|----------------|---|--|--|-------------------------------------|------------------------|--------------------------------------|---------------|--|----------------------|------------------------------|-----------------------|---|---------------|
| , A            | Physici  |                | Decedent's Name (First, Middle,   |  | J. Broome  |                                     |                        |                                      |               | Date of Dea<br>Month                     |                      | Yea<br>2008                  | 3                     | 3. Time of E                            |               |
| 4              | /Medic<br>Examin   |                | 4a. Facility Name (If not institution,  |  |  |                                     | own, or I              | Location of Dea                      | _             | u y                                      | -                    | County of De                 |                       | 7545                                    |               |
|                |  |                | Prince George's Hosp  | ital   |  | Cheve                               | rly                    |                                      |               |  | Prin                 | ce Georg                     | ge's                  |   |               |
|                | Funeral<br>Director  |                | 5. Social Security Number 6 219-28-5741   | .Sex 7.A<br>1 M 2 M F  | ge (In yrs. last birthday)<br>75 Yrs.                          | If Under 1<br>Months                | Days                   | If Under 24 Hrs<br>Hours Min         |               | Date of Birtl<br>(Month, Day<br>ugust 25 | y, Year)             |                              | irthplace<br>Country) | e (State or                             | Foreign       |
|                | and w  |                | Usual Residence of Decedent  10a. State 10b. County   |  | 10c. City, Town or Lo  | cation                              |                        |                                      |               |  |                      |                              | 10d                   | Inside City                             | v Limits      |
|                | f sho  | 5              | MD Prince G   | eorges   | Upper Marlbo   |                                     |                        |                                      |               |  |                      |                              |                       | 1 ☐ Yes                                 |               |
|                | the N<br>28a-  | Director       | 10e. Street and Number  | corges   | Opper Maribo   | 10f. Zip 0                          | Code                   |                                      |               |  | 10a. Citiz           | zen of What (                | Country?              | ?                                       |               |
|                | 3a or  |                | 10815 Joyceton Court  |  |  |                                     |                        | 0774                                 |               | -  | USA                  |                              | ,                     |   |               |
|                | ms 2   | Funeral        | 11. Marital Status  | 12. Was Decedent   | Ever in U.S. 13.   | Was Decede                          |                        | panic Origin? (<br>, Mexican, Pue    | Specify       | Yes or No-                               |                      | 14. Race - An                |                       |   | -             |
| 21215-0036     | s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | <u>م</u>       | 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced  | Armed Forces'  1 ☐ Yes 2 ☑  If Yes, Give  Year or Dates:       | No   | if Yes, speci<br>1 ☐ Yes 2Ì         |                        | n, Mexican, Pue<br>Specify:          | rto Ric       | an, etc.)                                |                      | Black, Wh<br>Specify:        | ite, etc.<br>Black    |   |               |
| Ö              | 72 horatur   | Completed      | 15. Decedent's<br>(Specify only highest   | Education  | 16a. Dece  | dent's Usual                        | Occupa                 | tion                                 | orkina        |  | 16b. Kir             | nd of Busines                |                       |   |               |
| 21             | within 7<br>ene.<br>than "r<br>he Med  | ag l           | Elementary/Secondary (0-12)   | College (1-4or   | 5+) (Give  | DO NOT use                          | retired)               | uring most of wo                     | JINIIY        |  |                      |                              |                       |   |               |
| CA             | ygier<br>ygier<br>her th   | S              | 12  |  | Cafe   | eria Mar                            | -                      |                                      |               |  |                      | Public S                     | chool                 | <u>s</u>                                |               |
| Maryland       | ould be filed w<br>Mental Hygie<br>harked other ti<br>natic event, th  | Be             | 17. Father's Name (First, Middle, La  | ast)   |  |                                     |                        | 18. Mother's Na                      | ime (F        | irst, Middle,                            | Maiden               | Surname)                     |                       |   |               |
| yla            | 2 should to and Menion is marked raumatic e  | 유              |   | ence Janey   | 401.44.77  |                                     | (2)                    | 444 / 5                              |               |  | attie C              |                              |                       |   |               |
| Mai            | d2 st<br>th and<br>7 is n<br>traun   |                | 19a. Informant's Name/Relationship  |  |  |                                     |                        | nd Number or F                       |               |  |                      |                              | , Zip Co              | de)                                     |               |
| e)             | 1 and 2<br>Health<br>tem 27 i  |                | Keith A. Broome - Soi<br>20a. Method of Disposition   | 1  |  |                                     |                        | ourt, Upper                          | r Mai<br>Date |  |                      | cation - City                | or Town               | State                                   |               |
| 2              | ages<br>int of<br>t: if it   |                | 1X Burial 2 ☐ Cremation 3   |  |  |                                     |                        |                                      |               |  | 200. 20              | oution Oity                  | J. 104111,            | Qualo                                   |               |
| Baltimore,     | artme<br>ortani<br>Injuri  |                | 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Li                                     |  | St. John L   | IM Churc<br>2. Name and             |                        |                                      | 5/200         | 8  | _Lusb                | y, MD                        |                       |   |               |
| Ba             | permit. Pages 1 and 2<br>Department of Health of<br>Important: If item 27 is<br>any Injury or other tra<br>once.   |                | Madep a.  | Servill  | Se   | well Fune                           | ral Hor                | ne, P.A., 14                         |               |  |                      | , Prince F                   | _                     |   |               |
|                | Physician  |                | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List or<br>Immediate Cause (Final   | omplications that cause  | ed the death. Do not en  |                                     |                        |                                      |               | ,  | rrest,               |                              | Int<br>Or             | oproximate<br>terval Betw<br>nset and D | veen<br>Death |
| 1              | /Medical<br>Examiner   |                | disease or condition resulting in death)  | Due to (or as  | s a consequence of):   | O N                                 |                        | igthra                               |               |  |                      |                              | +                     |   |               |
|                |  | Jer            | Sequentially list conditions, if any, leading to immediate  | b. Due to (or as   | s a consequence of):   |                                     |                        |                                      |               |  |                      |                              | +                     |   |               |
|                | cuted<br>id<br>ransit  | Examiner       | if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Diabet   | Tes  |                                     |                        |                                      |               |  |                      |                              |                       |   |               |
| 0              | be executed<br>ician and<br>burial-transit   | Ä              | resulting in death) Last  | Due to (or as  | s a consequence of):   |                                     |                        |                                      |               |  |                      |                              |                       |   |               |
| 8760,          | icate be ex<br>physician<br>s the buria  | dical          | 8   | d  |  |                                     |                        |                                      |               |  |                      |                              | +                     |   |               |
| 9              | ertific<br>ling p  |                | IF FEMALE:  | 000 16   |  |                                     |                        |                                      |               |  | T                    |                              |                       |   |               |
| Вох            | leath certific<br>attending p<br>i for use as  | Physician/Me   | 23b. Was decedent pregnant in the past 12 months?   |  | 2 Fetal death 3  | ⊒Ectopic pre<br>⊒ Other <i>(spe</i> |                        |                                      |               |  | 2                    | 23d. Date of o<br>Month      | delivery<br>Da        | ıy Y                                    | /ear          |
| P.O.           | the de   | ysic           | 1 ☐ Yes 2 🗖 No<br>9 ☐ Unknown   | 9□Unknown  | at time of death 51  | _ Other (spe                        | city)                  |                                      |               |  |                      |                              |                       |   |               |
|                | The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit  | by Ph          | Part II. Other significant condition  | s contributing to death  | but not resulting in the u                                     | nderlying car                       | use give               | n in Part I.                         |               | 23e. Did to                              | obacco u             | se contribute                | to the c              | ause of de                              | eath?         |
| Vital Records, | w require<br>been sig<br>should b  | edt            |   |  |  |                                     |                        |                                      | .             | 1 🗆 1                                    | Yes 2[               | □No 3□                       | Probabl               | y 4 <b>∑</b> Ų                          | Jnknown       |
| ecc            | law ras be   | Completed      |   |  | -9-19-1  |                                     |                        |                                      | . [           | 24a. Was                                 |                      | 24b. Were                    | autopsy               | findings a<br>letion of ca              | available     |
| =<br>H         | The<br>ate h   | 5              |   |  |  |                                     |                        |                                      |               | perfo<br>1∐ Yes                          | rmed?<br>200 No      | death                        | ?                     | □No                                     |               |
| /ita           | sician: The law<br>s certificate has b<br>irector, page 2 s  | Be             | 25. Was case referred to medical examiner?  | Unanitali  |  |                                     | l ou                   | 26. Place of De                      | eath (C       | heck only o                              | ne)                  |                              |                       |   |               |
| or             | Physician:<br>this certific<br>ral director,   | မ              | 1 ☐ Yes 2 No  | Hospital:  |  |                                     |                        | 4 LI Nursing                         | 7             |  |                      | 5 □Other (S                  | pecify)               |   |               |
| n              | ing F  | ion            | 27. Manner of Death 1 X Natural 5 ☐ Pending   | 28a. Date of Inj<br>(Month, D                                  | iury 28b. Time o<br>a <i>y Year)</i> Injury                    | M 28                                | Bc. Injury<br>Work     |                                      | 280           | . Describe I                             | how injur            | y occurred                   |                       |   |               |
| isio           | death<br>death<br>stor:<br>/ the   | icat           | 2 Accident investiga 3 Suicide 6 Could no   | t be 290 Place of in   | ijury - At home, farm, st                                      |                                     |                        | ′es 2 □ No                           | 286           | Location /                               | Stroot an            | d Number or                  | Pural P               | Pourto Num                              | hor           |
| Division       | al or A<br>after<br>il Dire  | Certification: | 4 ☐ Homicide determin   | ed building, e   | tc. (Specify)  |                                     | 011100                 |                                      | 201.          | City or Tov                              |                      |                              | riurai ri             | oute rum                                | Der,          |
|                | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page   | Medical (      | 29a. Certifier (Check only one) Certifying 2 Medica! E  | Physician: To the bes<br>xaminer: On the basis<br>and manner s | t of my knowledge, deat<br>of examination and/or in<br>stated. | th occurred a<br>evestigation,      | at the tim<br>in my op | e, date and plac<br>pinion, death oc | ce, and       | due to the<br>at the time,               | cause(s)<br>date and | and manner<br>d place, and o | as state<br>lue to th | e cause(s                               | ;)            |
|                | To th<br>withir<br>To th<br>comp   | Me             | 29b. Signature and title of certifier   |  | . ^  | 29c.                                | License                | number                               |               |  | 29d. Dat             | e signed (Mo                 | nth, Da               | y, Year)                                |               |
|                |  |                |   | 11teo  | , MI   |                                     | 058                    | 1957                                 |               |  | 0                    | 5-11                         | -08                   | 1                                       |               |
| 10             | , A.   |                | 30. Name and address of person w  | h completed cause of   | death (Item 23a) (Type,  | Print)                              |                        | 20                                   |               | 0.                                       | /·                   |                              |                       |   |               |
| aku            | V 4  |                | 31. Date filed (Month, Day, Year)   | 32 Racie   | CHEVERLY<br>trans Signature                                    | HOSPI                               | THE                    | DK                                   |               | CHEV                                     | ERLY                 | MD                           | 20                    | 785                                     |               |
|                | Sta<br>Registi   |                | MAY   | 1 3 2008   | Brever &   | 600                                 | W.                     |                                      |               |  |                      |                              |                       |   |               |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 17269 08-03846 State of Maryland / Department of Health and Mental Hygiene Faye Elizabeth Braxton Certificate of Death 1- For State Reg. No. 3. Time of Death 2. Date of Death . Decedent's Name (First, Middle,Last) Month Day May 20, 2008 Physician/ 0735 hrs odiçal Examiner Fave Elizabeth Braxton 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) St. Mary's Leonardtown Saint Mary's Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Funeral Hours Days Country) Maryland 08/16/1958 49 Director 217-78-7251 1 M 2XF Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 X No Mechanicsville Maryland St. Mary's 10g. Citizen of What Country? Director 10f Zin Code 10e. Street and Number United States 28825 Braxton Way 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-12. Was Decedent Ever in U.S. Funeral If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status White, etc. Armed Forces' 1 X Never Married 2 Married 2 X No Yes Specify: **Black** 1 Yes 2 X No specify: f Yes, Give Year 4 Divorced 3 Widowed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done ģ 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 721 House Keeping Baltimore, MD 21215-0036 pernit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than House Keeper 12 18.Mother's Name (First, Middle, Maiden Surname) tem 27 is marked other it traumatic event, the Me 17. Father's Name (First, Middle, Last) Clara Edith Woodland William Louis Braxton Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 2492 Lake Drive Apt #165 Waldorf, Maryland 20601 Saronna Braxton / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State or other 05/24/2008 Mechanicsville, MD. Ebenezer Cemetery Donation 5 Other Soe 22. Name and Address of Facility Brinsfield Funeral Home, P.A. on the of Funeral Service Brinsfield, JR. M00052 22955 Hollywood Road Leonardtown, MD N. Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset and Physician failure. List only one cause on each line Death /Medical Asthma Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Physician/Medical X UNPENDED #23a,PII,27,perME,G880, 6/5/08 TI attending physician or use as the burial 23d Date of delivery Box 68760, 23c. If yes, outcome of pregnancy Year Month Day 3 Ectopic pregnancy 23b. Was decedent pregnant in the Fetal death Live birth Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ Hypertensive cardiovascular disease 24b. Were autopsy findings available Completed 24a. Was an Records, s been s prior to completion of cause of autopsy performed? death? has ✓ Yes ✓ Yes 2 No page 2 certificate 26.Place of Death (Check only one) 25. Was case referred to medical Other: Nursing Home 5 Residence 6 Other: Hospital: 1 Inpatient DOA 2 🗸 ER/Outpatient 3 After this 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 27. Manner of Death ë Yes 2 No 1 X Natural 5 Pending death. 28f. Location (Street and Number or Rural Route Number, City Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. by or Town, State)

Division of Vital Director: To the Hospital or within 24 hours at To the Funeral L

Certificati 6 Could not be 3 Suicide determined Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 2 W Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and marrier stated 29b. Signature and title of certific 30. Name and address of werson who completed cause of death (Itam 230)

O.C.M.E.

Mary G. Ripple MD. 31. Date filed (Month, Day, Year) State

Deputy Chief Medical Examiner

29c. License number

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 21, 2008

Registrar

OCME

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 8, Day 2008 Year **Physician** 2200 PM Harry Luman Cleveland /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 2, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days Min. Washington, D.C 1924 Director 577-24-2345 84 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show eny Injury or other traumatic event, the Medical Expresser must be netited at 1 Yes 2 No Director MD Sandy Spring Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17619 Norwood Road 20860 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 29 Yes 2 □ No If Yes, Give Year or Dates: 1943–46 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: White δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Religious Order Clergyman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis F. Cleveland Helena V. Smith ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17617 Norwood Road Sandy Spring, MD 20860 Charles Kight/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 05/13/08 Beltsville, MD ature of Funeral Service Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) neumonia **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Attending Physician: The law requires that the death certificate be executed bleed and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav Year Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 ☐ Unknown 1 🗌 Yes 2 🗌 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6 Philip 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18/01 OINEY pr PRINCE huanso 1 6 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State 13 2008 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 05 ď8 1658 Clark Margaret 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WMHS Braddock Campus Cumberland Allegany If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Months Days Hours 1 🗌 M 84 200-20-3025 3-13-1924 PAUsual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 Yes 2 □ No MD Allegany Corriganville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 12819 Ellerslie Rd NW PO Box 354 21524 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Specify. 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Michael Anthony Sedlitsky Fannie (NMN) Nagi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 197 Corriganville, MD Charmaine Getz/ Daughter 21524 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Restlawn Mem. Gardens 5-21-2008 LaVale, MD 22. Name and Address of Facility Harvey H. Zeigler Funeral Home Inc 21. Signature of Funeral Service Licens <u>169 Clarence St Hyndman PA 15545</u> 23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final maybo Metasth disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to infine right cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐Live birth 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? accomys 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Zunknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No autopsy performed 2 40 25. Was car examine 1 ☐ Yes

**Examiner** Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed and -trar Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending | þ þ Completed Be P this After 1 Certification: I Director: d in by the within 24 hours aft

To the Funeral Di

completely filled ir

**Physician** 

/Medical

Examiner

Director

Funeral

þ

Completed

Be

2

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show ant; If Item 27 is marked other than "natural" or healtical Examiner must be notified at

permit. Pages 1
Department of F
Important: If Ite
any Injury or ot

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

Medical 10 DK nas

State Registrar

27. Manner

1 Nat

3 Sui 4 ☐ Hor

29a. Certific

29b. Signature and title of certif

| se refe                  | red to medical            |                                |                            |          | 26. Place of Dea                          | ath (Check only one)  |
|--------------------------|---------------------------|--------------------------------|----------------------------|----------|---|---|
| ***************          | No                        | Hospital: 1 Inpatient 2[       | ☐ ER/Outpatient            | 3□ [     | OOA Other: 4 Nursing H                    | Home 5 ☐ Residence 6 ☐ Other (Specify)  |
| of Deat<br>ural<br>ident | 5 ☐ Pending investigation |                                | 28b. Time of<br>Injury     | M        | 28c. Injury at<br>Work?<br>1 ☐ Yes 2 ☐ No | 28d. Describe how injury occurred   |
| cide<br>nicide           | 6 Could not be determined |                                | home, farm, stree<br>cify) | t, facto | ory, office                               | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |
| er                       | 1 Certifying Ph           | nysician: To the best of my ki | nowledge, death o          | ccurre   | ed at the time, date and place            | e, and due to the cause(s) and manner as stated.                                |

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d, Date signed (Month, Day, Year)

, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Drive Cumberland Maryland 21502 904 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2008 CULP, JR. 8:08 P M HARRY PERCY May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Somerset 3327 Lawsonia Road Crisfield 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 X M 2 □ F Days 61 Director 216-44-8002 Somerset December 28,1946 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. nt: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Ex-miner must be notified at 1 ☐ Yes 2 ☑ No Directo Crisfield Maryland Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21817 USA Funeral 3327 Lawsonia Road 12. Was Decedent Ever in U.S.
Armed Forces?

1 ⊠Yes 2□No U.S.
If Yes, Give Air
Year or Dates: Force 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No þ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Force er than "natur, Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembly Worker Petroleum Products 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leila Nelson ပ္ Harry Percy Culp 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any Injury or other trau 3327 Lawsonia Road - Crisfield, Maryland 21817 <u>Jacqueline Culp ( Wife )</u> 20b. Place of Disposition (Name of cemetery, crematory or other place)
Asbury Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State May 16, 2008 Crisfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ricersee
Mary Beth Bradshaw 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 West Main Street - Crisfield, Maryland 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal cell cancel /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tra Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. signed by the 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has le 2 autopsy perform certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Certification: 1 XNatural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral I 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-14-08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 145 & Carroll St. Salebury, MD 21801 Bennett eninsula strar's Signature 31. Date filed (Monta 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month Polly P. Chiu 6:58 May 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 3212 Cordoba Street Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 3 F Director 215-74-7231 60 China April 4, 1948 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner rust be notified at 1 ☐Yes 2 ➡No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3212 Cordoba Street 20904 USA death \ by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Asian 1 ☐Yes 2 No Specify 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other the any Injury or other traumatic event, I'ms. Owner & Operator Alterations Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shing-Hei Wong Lai-Ho Kwong ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian K. Currey/Daughter 12314 Charles Road, Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State May 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2008 Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) ed by the detached t 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş Brain Metastasis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 ☐Yes 2 🗷 No 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 🖾 Natural 5 Pending investigation To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23743 May 12, 2008 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Martin Weltz 7525 Greenway Center Drive, Greenbelt, MD 20770 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

|             |  |                | For State Registrar   | State of Ma  | ryland  | l / Depa<br><i>Cei</i>   | artment of F  | lealth a<br>Death           | and M  | ental Hyg                                 | jiene<br>Jieg. No.       | 008                           | 17274                                   |  |
|-------------|--|----------------|---|--|---|--|---|-----------------------------|--|---|--------------------------|-------------------------------|---|--|
| <b>5</b>    | Physici<br>/Medic  |                | 1. Decedent's Name (First, Middle )   | e, Last) 05 EPI+   | D   | 000  | HOE   |                             |  | 2. Date of Dea<br>Month                   |                          | Vear                          | 3. Time of Death                        |  |
|             | Examin   |                | 4a. Facility Name (If not institution  Anne Arundel M   |  | c   |  | 4b. City, Town, o                                     | lis                         |  |   |                          |                               |   |  |
|             | Funeral<br>Director  |                | 5. Social Security Number 291-20-5168 Usual Residence of Decedent   | 6. Sex 7. Age  | (In yrs. las  | st birthday)<br>Yrs.   | If Under 1 Year<br>Months Days                        | If Under:<br>Hours          | 24 Hrs.<br>Min.  | 8. Date of Birth<br>(Month, Day<br>7/6/19 | 27<br>27                 | 9. Birth<br>Cou               | place (State or Foreign<br>ntry)<br>h10 |  |
|             | e Maryland<br>ta-f show<br>tifled at   | ctor           | 10a. State 10b. County  | Arundel  |   | y, Town or Location nnapolis   |   |                             |  |   |                          |                               | 10d. Inside City Limits 1 ☐ Yes 2 ☑ No  |  |
|             | with the   | Director       | 10e. Street and Number  | _  |   |  | 10f. Zip Code   |                             |  | 1   | 10g. Citize              |                               | intry?                                  |  |
| 215-0036    | be filed within 72 hours after death with the Maryland that Hygliene.  Id other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by Funeral     | 1511 Wincheste  11. Marital Status  1 □ Never Married 2 🍱 Married   | 9-   | 214 Was Decedent of H f Yes, specify Cuba 1 □ Yes 223No | ispanic Origin? (Specify Yes or No-<br>an, Mexican, Puerto Rican, etc.)  Specify:  USA  14. Race - American Indian, Black, White, etc.  Specify: White |   |                             |  |   | etc.                     |                               |   |  |
|             | filed within 72 hours<br>I Hygiene.<br>other than "natural"<br>ent, the Medical Exi  | Completed b    | 3 ☐ Widowed 4 ☐ Divorced  15. Deceder (Specify only higher  Elementary/Secondary (0-12)   | dent's Usual Occup<br>kind of work done<br>DO NOT use retired              | ation<br>during most                                    | t of workin  | ng  |                             | Ac. Country of Death   Anne   Arundel                      |   |                          |                               |   |  |
| 7           | iled with  | Con            |   | College (1-4or 5+<br>5+  | <u> </u>  | Ret.   | Col.  | 19 Motho                    | wa Nama  | /First Middle                             |                          |                               |   |  |
| _           |  | To Be          | 17. Father's Name (First, Middle, Last)  John Patrick Donohoe   |  |   |  |   |                             | e Fi   | tzpatri                                   | ck                       |                               |   |  |
| Ma          | nd 2 shoulth and 27 is mirror ir traumi  |                | 19a. Informant's Name/Relationship (Type. Print)  Jane Donohoe  19b. Mailing Address (Street and Number or Rura  1511 Winchester Road A |  |   |  |   |                             |  |   |                          |                               |   |  |
| =           | Pages 1 and 2 should<br>nent of Health and Mer<br>nt; If item 27 is marke<br>iry or other traumatic  |                | 20a. Method of Disposition  1   Burial 2 □ Cremation  4 □ Donation 5 □ Other (S   |  | cer   | metery, crer   | sition (Name of<br>matory or other place<br>n Nationa |                             | _  |   |                          | •                             |   |  |
| Balti       | permit. Page<br>Department of<br>Important; If<br>any Injury or<br>once.   | 1 1<br>10 1    | 21. Signatural Funeral Sarvice  | Th-  |   | 22   |   | ss of Facilit               | y Har  | desty F                                   | unera                    | al Nome                       |   |  |
|             | Physician<br>/Medical<br>Examiner  |                | Immediate Cause (Final disease or condition resulting in death)   | conditions that caused to only one cause on each line  a.  Due to (or as a | nel S   | toy  | er the mode of dyir                                   | ng, such as                 | cardiac o  | or respiratory arr                        | rest,                    |                               | Onset and Death                         |  |
| 8/00,       | certificate be executed rding physician and ise as the burial-transit  | ical Examiner  |   |  |   |  |   |                             |  |   |                          | ]                             |   |  |
| O. Box og   | eath certific<br>attending p<br>for use as   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | Ectopic pregnancy  | <i>y</i>  |  |   |                             |  | ,   |                          |                               |   |  |
| coras, r    | w requires that the de<br>been signed by the<br>should be detached   | by             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                  |  |   |  |   |                             |  |   |                          |                               |   |  |
| Ž<br>Ž      | n: The law re-<br>licate has bee<br>r, page 2 shoi   | Completed      |   |  |   |  |   |                             |  |   | med?<br>2 No             | prior to co<br>death?         | ompletion of cause of                   |  |
| on or vital | ding Physician: The lav<br>h.<br>After this certificate has<br>funeral director, page 2 9  | tion: To Be    | 25. Was case referred to medica examiner?  1 ☐ Yes 2 ☐ No  27. Manner of Death  1 ☐ Natural 5 ☐ Pendin investigners.                    | R/Outpatien<br>28b. Time of<br>Injury                                      | of 28c. Injury at 28d. Describe                         |  |   |                             | ly one) esidence 6 □Other (Specify) be how injury occurred |   |                          |                               |   |  |
| DIVISI      | al or Atten<br>after deat<br>I Director:<br>d in by the  | Certification: | 3 Suicide 6 Could determ  | eet, factory, office   |   |  |   |                             |  |   |                          |                               |   |  |
|             | To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune   | Medical C      | 29a. Certifier (Check only one)  1 Certifyir 2 Medical  | ng Physician: To the best of Examiner: On the basis of Canada manner state | examinatio  | ledge, death<br>on and/or in   | n occurred at the tir<br>vestigation, in my o         | ne, date an<br>opinion, dea | nd place, a  | and due to the c<br>ed at the time, c     | ause(s) ai<br>date and p | nd manner as<br>lace, and due | stated.<br>to the cause(s)              |  |
| )           | withir comp  | ME             | 29b. Signature and title of cellifie  | Het  | us  |  | 29c. Licens   | e number                    | 438  | 2   | 9d. Date                 | signed (Month                 | , Day, Year)                            |  |
| 55          | ンの   | 4              | 30. N me and address of croon   | who completed cause of dea   | ath (Item 2   | (Type,   |   | HWA                         | ny A   | NURCO                                     | الان                     | MDZI                          | 401                                     |  |
|             | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year) MAY 1 2   |  | r's Signatu   | re   |   |                             |  |   |                          |                               | ,                                       |  |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                |  |               | State of Maryland / Dep<br>1 - State Registrar Ce  | eartment of Health and Me<br>Prtificate of Death                                     |   | ene<br>. No. 2008                             | 17275                                     |  |  |  |  |  |
|----------------|--|---------------|--|--|---|---|---|--|--|--|--|--|
|                |  |               | Decedent's Name (First, Middle, Last)  |  | Date of Death     Month                       |   | 3. Time of Death                          |  |  |  |  |  |
|                | Physici<br>/Medio  |               | Ruth Elizabeth DECKER  | 2008 Year  | 6:40 a. <sup>M</sup>                          |   |   |  |  |  |  |  |
|                | Examin   | er            | 4a. Facility Name (If not institution, give street and number)  Homewood Retirement  | 4b. City, Town, or Location of Death   |   | 4c. County of Death                           |   |  |  |  |  |  |
|                | Funeral  |               | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday   | Williamsport  Just If Under 1 Year   If Under 24 Hrs.                                | 8. Date of Birth<br>(Month, Day, Y            |   | ngton<br>place (State or Foreign<br>ntry) |  |  |  |  |  |
|                | Director   |               | 219-20-1122 1 M 2 XF 82 Yrs.   | Months Days Hours Min.   | Dec. 21,                                      | (ear) Cou                                     | ntry)<br>(aryland                         |  |  |  |  |  |
|                | and w  |               | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L  | ocation  |   |   | I0d. Inside City Limits                   |  |  |  |  |  |
|                | Maryli<br>-f sho   | ţō            |  | agerstown  |   |   | 1 ☐Yes 2XNo                               |  |  |  |  |  |
|                | h the  | Director      | 10e. Street and Number   | 10f. Zip Code  | 10g   | . Citizen of What Cou                         | ntry?                                     |  |  |  |  |  |
|                | 23a c  | ral           | 12804 Little Elliott Drive Apt.1   | 21742  | U   | ISA   |   |  |  |  |  |  |
| 21215-0036     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Event her must be neithed at ance.  | by Funeral    | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:   | Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F       | cify Yes or N <i>o-</i><br>Rican, etc.)       | 14. Race - Ameri<br>Black, White,<br>Specify: |   |  |  |  |  |  |
| 2-0            | 72 ho<br>'natur<br>(fical  | Completed     | 15. Decedent's Education (Specify only highest grade completed) (Giv   | a 16   | b. Kind of Business/Industry                  |   |   |  |  |  |  |  |
| 121            | within<br>ene.<br>than "   | dmo           | Elementary/Secondary (0-12) College (1-4or 5+)   | DO NOT use retired)  |   | retail store                                  |   |  |  |  |  |  |
| d 2            | filed I Hygir  | Be Co         | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name  |   |   |   |  |  |  |  |  |
| /lan           | 2 should be and Mental Is marked of raumatic ever  | To B          | Amos C. Rubeck   | Annie Ma   | e Timmon                                      | ıs  |   |  |  |  |  |  |
| Maryland       | 2 should<br>and Men<br>Is marke<br>raumatic  | o di          |  | ing Address (Street and Number or Rural  | · ·   |   |   |  |  |  |  |  |
| e,             | 1 and<br>Health<br>em 27   | 1             |  | 4 Little Elliott Dr  |   | c. Location - City or To                      |   |  |  |  |  |  |
| Baltimore,     | Pages<br>nent of<br>ant: If Ite<br>ury or o  |               | ILX Dullai 2 Li Ciellation 3 Li nellioval light State 1  | osition (Name of principle) ren Cemetery 5/19  |   | agerstown,                                    |   |  |  |  |  |  |
| a<br>≣:        | permit. F<br>Departm<br>Importar<br>any injur  |               |  | . Name and Address of Facility   |   | H FUNERAL                                     |   |  |  |  |  |  |
| <u> </u>       | 8 9 E 8 8  |               |  | 15 E. Wilson Blvd.   | , Hagers                                      | town, Md.                                     |   |  |  |  |  |  |
|                | Physician<br>/Medical  |               | 23a. Part 1. Enter the disease, or complications that, aused the death. Bo not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of ach line.  Immediate Cause (Final disease or condition resulting in death)  Due of rags a consequence of):  |  |   |   |   |  |  |  |  |  |
|                | Examiner   | ,             | Societally liet conditions, b. CHENWTHGHAPY  |  |   |   |   |  |  |  |  |  |
|                | rted<br> <br> -<br>  nsit  | Examiner      | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | trafice  | GEARS 1                                       |   |   |  |  |  |  |  |
| Ć.             | ificate be executed<br>g physician and<br>as the burial-transit  | Exal          | resulting in death) Last  Due to (or as a consequence of):   |  |   |   |   |  |  |  |  |  |
| 68760          | ate be<br>hysicia<br>he bu   | edical        | d  |  |   |   |   |  |  |  |  |  |
|                |  | Med           | IF FEMALE:   |  |   |   |   |  |  |  |  |  |
| P.O. Box       | w requires that the death certific<br>been signed by the attending p<br>should be detached for use as t  | Physician/M   | 23b. Was decedent pregnant in the past 12 months?  1   |  | 23d. Date of deliv<br>Month                   | ery<br>Day Ye ar                              |   |  |  |  |  |  |
| _              | es tha<br>igned<br>be det  | by P          | Part II. Other significant conditions contributing to death but not esulting in the t  |  | tobacco use contribute to the cause of death? |   |   |  |  |  |  |  |
| 0.0            | requii   | eted          | The way of the control of the contro |  | 1 L Yes                                       | 1 Yes 2 No 31 Probably 4 Unknown              |   |  |  |  |  |  |
| Vital Records, | The lay<br>ate has<br>bage 2   | Completed     | 25. Was case referred to medical   |  | 24a. Was an autopsy performed                 | opsy prior to completion of cause of death?   |   |  |  |  |  |  |
| 5              | ysicia<br>is certi<br>directo  | To Be         | examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie  | 26. Place of Death   | •       | ce 6 Other (Speci                             | 6.1                                       |  |  |  |  |  |
| n o            | iding Physician:<br>th.<br>After this certifics<br>funeral director, p   | D::T          | 27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) Injury  |  | 8d. Describe how                              |   | <u>y/</u>                                 |  |  |  |  |  |
| Division       | ttendl<br>death.<br>tor: A<br>the fu   | ertification: | Accident Investigation   | M 1 □Yes 2 □No   | 06  | =   | .=  |  |  |  |  |  |
| 2              | after after I Direct   | ertif         | 4 Homicide determined determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)   | eet, factory, office   | City or Town, S                               | et and Number or Rura<br>State)               | al Houte Number,                          |  |  |  |  |  |
|                | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, to   | edical C      | 29a. Certifier (Check only one)  1 Certifying Physiclen: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or i and manner stated.  | th occurred at the time, date and place, a nestigation, in my opinion, death occurre | and due to the cauded at the time, date       | se(s) and manner as a and place, and due to   | stated.<br>o the cause(s)                 |  |  |  |  |  |
|                | To the vithing to the complete | ž             | 29b. Signayla bettife for beginning  | 29c. License number  | 29d   | . Date signed (Month,                         | Day, Year)                                |  |  |  |  |  |
|                |  | }             | 30. Name and address of person who completed cause of death (Item 23a) (Type,  | Print) (1)   |   | 2/17/5  | w   |  |  |  |  |  |
| 5              | 16   |               | TEPHEN E METZWEN, MD 1747.4  | Paffer Fre 101 H   | FACOLASTO                                     | een, Uld                                      | 21742                                     |  |  |  |  |  |
| ı              | Stat<br>Registra   |               | 31. Date filed (Month, Day, Year)  MAY 1 5 2008  32. Fig. strar's Signature  | And I  |   | ,   |   |  |  |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 12:48 PM 41an 2008 la /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Trum erick If Under 1 Yes 6. Sex 1 X M 2 ☐ F If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 18, 1962 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Months Hours Yrs. 45 Director Dec. Virginia 164-58-9107 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 No Director Maryland Washington County Hagerstown 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 649 N. Mulberry Street U.S.A. 21740 items 23a Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 △Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ö 1 □Yes 2 No White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) <u>Truck Driver</u> Trucking Company 2 should be filed w and Mental Hygie Is marked other th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Allen H. Eshleman Phyllis Lorraine Bowman Howard Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>s</u> Health em 27 I <u>Phyllis L. Howard-mother</u> 3624 Horizon Dr. Lancaster, PA 17601 3altimore, item 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ţ, = ō Department c Important: If injury Smithsburg Crematory 5-10-2008 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee any i 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or an plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** inutes /Medical Due to (or as a consequace of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Physician/Medical the attending ph for use as the IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day 5 Other (specify) P.O. I ☐Yes 2☐No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 2 No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗆 Yes 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Plastic bag Taped 15, 2008 Unknown 1 ☐Yes 2 No death head 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: h15 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number City or Town, State) 5361 Spectrum Dr filled in by 4 Homicide MD rederick Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie 29c. License number

State

Registrar MAY 1 5 200

Hlankonrer 31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a)



## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

| 2008 172 | 7 |
|----------|---|
|----------|---|

|  |  | 1- For State Registrar   |                | icate of Dea  |  | • •  | <b>20</b> eg. No.                       | 08 1727                                      |  |  |
|--|--|--|----------------|---|--|--|---|--|--|--|
| Physicia<br>Iedical Examir   |  | Decedent's Name (First, Middle,Last)   |                |   |  | Date of Dea     Month                              | th<br>Day Year                          | 3. Time of Death                             |  |  |
| 74   |  | 4a. Facility Name (if not institution, give street and number)   |                | 4b. City  | , Town, or Location  | May 5, 20<br>of Death                              | 4c. County of De                        |  |  |  |
|  |  | 1118 August Drive  5. Social Security Number 6. Sex 7. Age (   | la             |   | napolis  |  | Anne Aruno                              |  |  |  |
| Funeral<br>Director  |  | 5. Social Security Number 6. Sex 7. Age (  | In yrs. last b |   | nder 1 Year If Under<br>oths Days Hours  | 1.0  |   | Birthplace (State or reign CANADA            |  |  |
| <b>A</b>   |  | Usual Residence of Decedent  |                |   |  | 1 1 22 0   | , _,,                                   |  |  |  |
| d<br>how any   |  | 10a. State 10b. County 10  MARYLAND ANNE ARUNDEL   | Dc. City, Tov  | wn or Location  | NAPOLIS  |  |   | 10d. Inside City Limits  1 X Yes 2 No        |  |  |
| Aaryland<br>28a-f show<br>Lat once   | ecto   | 10e. Street and Number   |                |   | Zip Code   |  | 0g. Citizen of What C                   |  |  |  |
| th the N<br>23a or ?<br>rotified   | ä  | 1118 AUGUST DRIVE  |                |   | 214  |  | UNITED :                                | STATES                                       |  |  |
| eath wi  | Funeral  | 11. Marital Status 1 Never Married 2 Married Armed Forces?   |                | 13. Was Dece<br>If Yes, spe                             | dent of Hispanic Original Control Original Control Original Control Original Control Original Control O | gin? ( Specify Yes or No<br>ı, Puerto Rican, etc.) | 14. Race - An<br>White, etc             | nerican Indian, Black,                       |  |  |
| after d  | by Fu  | 3 Widowed 4 X Divorced If Yes, Give Year or Dates:   | No             |   | 2 X No specify:  |  | Specify:                                | WHITE  |  |  |
| 2 hours "natu  |  | 15. Decedent's Education (Specify only highest grade complementary/Secondary (0-12)  College (1-4 or 5+) |                | <ul> <li>Decedent's Usu<br/>during most of v</li> </ul> | al Occupation (Give vorking life. DO NOT   | kind of work done use retired)                     | 16b. Kind of Busine                     | ss/Industry                                  |  |  |
| 5-0036<br>led within 7<br>Hygiene.<br>lother than  | ompleted   | 4  |                | S   | ALESPERSO  | N  | C                                       | ARPET  |  |  |
| ID 21215-0036<br>should be filed within 72 hou<br>and Mental Hygiene.<br>7 is marked other than "nat<br>natic event, the Medical Exa   | Be Co  | 17. Father's Name (First, Middle, Last)  THOMAS R. FISCHEL   |                |   |  | 's Name (First, Middle,  A TOMEK                   | Maiden Surname)                         |  |  |  |
| 212<br>hould be<br>and Ments<br>is mark  | To B   | 19a. Informant's Name/Relationship (Type, Print )  |                |   | ss (Street and Nun   | nber or Rural Route Nur                            |   |  |  |  |
| ore, MD 21215-00<br>is: 1 and 2 should be filed win<br>of Health and Mental Hygien<br>If item 27 is marked other<br>her traumatic event, the M   | 1  | DEBORAH A. FISCHEL/SISTER  20a. Method of Disposition  |                | 15 NUTWE  | lame of comptent   | LOTHIAN, MA  | 20c Location City                       |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once |  | 1 Burial 2 X Cremation 3 Removal from State  | CHESA          | PEAKE CR  | EMATION  | MAY 7 2008   | 200. Location - City                    | ,  |  |  |
| taltin<br>rmit. P<br>spartme<br>iportan<br>jury or   |  | 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee                                    | CENTE          |   | nd Address of Facility   | ZUU8<br>FELLOWS, H                                 | STEVENSVI                               | LLE, MARYLAND<br>E NEWNAM<br>L4 BESTGATE     |  |  |
|  | )  | 23a. Part I. Enter the disease, or complication that caused the  | 0672           | K()AI)_   | ANNAPOLIS  | - MARYLAND   | 71401                                   |  |  |  |
| Physician<br>/Medical  |  | failure. List only one cause on each line.  Immediate Cause (Final disease a, Contact Gunshot)           |                |   | e or dying, such as c  | ardiac or respiratory ari                          | est, shock, or heart                    | Approximate Interval Between Onset and Death |  |  |
| xaminer  |  | or condition resulting in death)  Due to (or as a consequence of):                                       |                |   |  |  |   |  |  |  |
|  | Jer  | Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):             |                |   |  |  |   |  |  |  |
|  | if any, leading to immediate couca: Enter Underlying Couca (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of): |  |                |   |  |  |   |  |  |  |
| xecuted  |  | d.   |                |   |  |  |   |  |  |  |
| 760, Icate be executed physician and the burial - transi   | Medical  | UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome  | of pregnanc    |   |  |  | 23d. Date of deliv                      | (env   |  |  |
| Sox 687  Jeath certificate attending plant for use as the  | sician/l   | 23b. Was decedent pregnant in the past 12 months?  |                | 2 Fetal dear  |  | c pregnancy  | Month                                   | Day Year                                     |  |  |
| Box<br>e death c<br>the atten  | Physic   | 1 Yes 2 No 9 Unknown g Unknown   |                | 5 Other (S  | pecify)  |  |   |  |  |  |
| P.C  | ھ  | Part II. Other significant conditions contributing to death be   | ut not result  | ing in the underlyi                                     | ng cause given in Pa   |  |   | to the cause of death?                       |  |  |
| ords, P.C. w requires that is been signed I should be deta   | eted   |  | · · ·          |   |  | 24a. Was   | an 24b. Were                            | autopsy findings available                   |  |  |
| tal Recol  | Completed  |  |                | · · · · · · ·   |  |  | prior death 2 No 1                      | to completion of cause of ? Yes 2 No         |  |  |
| certi  | Ğ<br>Be  | 25. Was case referred to medical examiner?   |                |   | 26.Place of Death  |  |   |  |  |  |
| n of Viting Physic   | ٩  | 1 Yes 2 No Inpatient 27. Manner of Death 28a, Date of Injury   | 286            | Outpatient 3  | DOA Other 4  | Nursing Home 5                                     | Residence 6 Ot                          | her: Scene                                   |  |  |
|  | ation  | 1 Natural 5 Pending POUND: Day, Year May 5, 2008   | FC             | OUND:<br>20 hrs   | 1 Yes 2  | Subject sho  |   |  |  |  |
| Division as or Attendii rs after death.  | Certification:   | 3 Suicide 6 Could not be 28e. Place of Injury  | - At home,     |   | ry, office building, et  | or Town, S   | tate)                                   | Rural Route Number, City                     |  |  |
|  |  | 4 Homicide determined (Specify) reside   |                | leath occurred at the                                   | ne time, date and pla  |  | Drivé, Annapolis, Me(s) and manner as s |  |  |  |
| To the within To the comple  | Medical  | one) 2 Medical Examiner: On the basis of examin and manner stated.                                       | ation and/or   | r investigation, in r                                   | ny opinion, death oc   | curred at the time, date                           | and place, and due to                   | the cause(s)                                 |  |  |
|  | 2  | 29h Signature and title of certifier   | $\cap$ $\cap$  | 2   | 9c. License number O.C.M.E.  |  | 29d. Date signed (iii                   | Month, Day, Year)                            |  |  |
| James A  | J.   | 30. Name and address of person who completed cause of deat   | h (Item 23a)   | )   |  | ·  | , 5, 2000                               |  |  |  |
| 1400   |  | Patricia Aronica-Pollak MD. Assistant Med  |                | miner 111 I   | Penn Street, Ba  | altimore, MD 2120                                  | 1                                       |  |  |  |
| Sta<br>Registra  |  | 31. Date filed (Month, Day, Year) MAY 1 2 2008 32. Jegistrar's 3   | Signature      | South   |  |  |   |  |  |  |
| DHMH 17 Rev 1/200  | 01   | ,  | 0              | RIGINAL   |  |  |   |  |  |  |

DHMH 17 Rev 1/2001 OCME 2006

Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month May 9, 2008 Jessica Helaine Forman /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Montgomery General Hospital Montgomery Olney If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Oct 13, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 T F 1946 220-50-4026 61 Director Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location r 28a-f show notified at Director MD **Brookeville** Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? th and Mental Hygiene. 7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be r 3001 Quail Hollow Terrace 20833 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: ģ <sup>Specify:</sup> White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Public School Dance Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Balbos Jean Levy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3001 Quail Hollow Terrace Brookeville, MD 20833 19a. Informant's Name/Relationship (Type. Print) Arnold Forman/husband permit. Pages 1 and Department of Health Important: If fem 27: any Injury or other tra Health a 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Chesapeake Crematory 05/13/08 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** oF a Aben ocarcinoma unknown disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. signed by the attending physician be detached for use as the burial IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 9□Unknown 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No Completed 24a. Was an 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 ☐ Yes 2 No 1 Inpatient ပ 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes after death. death. 2 □ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a

To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State

702EbH KAPLY 31. Date filed (Month, Day, Year) MAY 13 2008

29a. Certifier (Check only one)

29b. Signature and

18111 PRINCE 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D 35635

DR

DHMH 17 Rev 1/2001

Registrar

OLNEY

2008

29d. Date signed (Month, Day, Year)

MAY

17278

0349 А м

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2√€ No

Maryland

Black, White, etc.

Month

Dav

3 Probably 4 □Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Year

**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

MAY 13 2008

Ragistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ethel Fuccile 10:15 PM May 6, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗓 F Yrs Director 150-32-0507 90 3/22/1918 England Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 XYes 2 □ No Director Maryland| Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 933 Edgewood Rd., Apt. 305 21403 USA Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Items 23sury or other traumatic event, the Medical Examiner must by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No White Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Computer Operator Insurance 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Standring Annie Birkett 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra Gerard Buckley/ Son 2116 E. Chesapeake Harbour Dr., Annapolis, MD 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 5-9-08 Edgewater, MD 21. Signature of Players Sepice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home Male 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or is a consequence of): minutes /Medical flash pulmonary eclem **Examiner** veusus Sequentially list on difficient if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine neuronusula Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the l IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hyperlensi-1 ☐ Yes 2 × 0 3 Probably 4 ☐Unknown Completed pothyroidism 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2000 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 10 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of De th Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury Vatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident s after death, af Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Bedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D62242 MD

State Registrar 2001

medical

AAMC

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sullivan

MAY 0 9 2008

31. Date filed (Month, Day, Year)

Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month **Physician** Year Charles Richard Frev 05 15 08 1801 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WMHS-Braddock Campus Allegany Cumberland 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 X M 2 □ F 059-22-8345 Director 12/19/1929 78 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or Items 23a or 28a-t show 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Keyser Mineral 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? HC 72 Box 394 26726 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1949— If Yes, Give Year or Dates: 1971 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 【XNo þ Specify. 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Major U.S. Army permit. Pages 1 and 2 should be file.
Department of Health and Mental Hygh.
Important: If item 27 is marked any injury or other to once. injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Clarence Emma Katherine Gallagher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Frey / Wife HC 72, Box 394, Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Cumberland Crematory 05/16/2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, P.A. 21. Signature of Funeral Service Licenses 404 Decatur Street, Cumberland, MD 21502 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Adenocarcinoma of Urinary Bladder June 2007 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pulmonary Metastasis November 2007 Due to (or as a consequence of Examine that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: for use 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient ဥ 2 ER/Outpatient 3 DOA 27. Magner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Natural 5 ☐ Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nLA Dr. Alida Podrumar 904 Seton Drive Cumberland, MD. 21502 Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 6 2008 Registrar

|                            |  | 1                            | State of Maryland / Department  | artment of Health and M<br>rtificate of Death   | lental Hygiene<br>Reg. No. <b>2</b> (  | 108 17282  |  |  |  |
|----------------------------|--|------------------------------|---|---|--|--|--|--|--|
|                            | Physicia   | an                           | 1. Decedent's Name (First, Middle, Last)  |   | 2. Date of Death<br>Month Day  | Year 2:40 PM   |  |  |  |
|                            | /Medic   | al                           | Robert Henry Garlock, Jr.  4a. Facility Name (If not institution, give street and number)   | May 6 2<br>4c. County   | .000   |  |  |  |  |
| )                          | Examin   | <b>-</b> 1                   | Washington County Hosptial  | Hagerstown  | Washin   | gton County  |  |  |  |
|                            | Funeral  |                              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,   | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.  | 8. Date of Birth (Month, Day, Year)  | Birthplace (State or Foreign Country)                  |  |  |  |
| L                          | Director   |                              | 214-28-7234 1 Table 1 Table 2 F Table 75 Yrs.   |   | Nov. 6,1932  | Maryland   |  |  |  |
|                            | ow at  |                              | 10a. State 10b. County 10c. City, Town or Let   | ocation   |  | 10d. Inside City Limits                                |  |  |  |
|                            | a-f sh   | ctor                         | Maryland Washington County   Clear Spr  | ing   |  | 1 □Yes 2 XNo   |  |  |  |
|                            | or 28  | Director                     | 10e. Street and Number  | 10f. Zip Code   | 10g. Citizen of  | What Country?  |  |  |  |
|                            | eath v   | Funeral                      | 13428 Draper Rd.  11. Marital Status 12. Was Decedent Ever in U.S. 13.  | 21722 Was Decedent of Hispanic Origin? (Sp  |  | e - American Indian,                                   |  |  |  |
| (0                         | filed within 72 hours after death with the Maryland<br>Hygiene.<br>yther than "natural", or Items 23a or 28a-f show<br>ent, the Medical Examiner must be notified at   | Fun                          | Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No. 5.2  | If Yes, specify Cuban, Mexican, Puerto  1 ☐ Yes 2 🛣 No Specify:   |  | ck, White, etc.<br>y: White                            |  |  |  |
| 93                         | ours a   | d by                         | 1975  |   |  |  |  |  |  |
| 5                          | "natu  | lete                         | 15. Decedent's Education 16a. Dece<br>(Specify only highest grade completed) (Giw<br>life.  | edent's Usual Occupation<br>the kind of work done during most of work<br>DO NOT use retired)  |  | usiness/Industry                                       |  |  |  |
| 12                         | within jene.  r than the M   | Completed                    | Elementary/Secondary (0-12) College (1-4or 5+) Crew   |   |  | Airforce   |  |  |  |
| b                          | e filed<br>al Hyg<br>other   | Be C                         | 17. Father's Name (First, Middle, Last)   |   | e (First, Middle, Maiden Surnar  | ·  |  |  |  |
| ylaı                       | should be<br>nd Mental<br>marked c   | To E                         | Robert Henry Garlock, Sr.   |   | a E. Wetzel Garlock Domer er or Rural Route Number, City or Town, State, Zip Code) |  |  |  |  |
| Maryland 21215-0036        | d 2 sh<br>th and<br>7 is rr<br>traurr  |                              | Total Antonia Control of Control | 2 Heavenly Acres F  |  |  |  |  |  |
|                            | s 1 and<br>f Health<br>item 27<br>other tr   |                              | 20a. Method of Disposition 20b. Place of Disposition  | osition (Name of ematory or other place)  |  | - City or Town, State                                  |  |  |  |
| E C                        | Pages<br>nent of I<br>ant: If its<br>ury or o  |                              | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Smithsbu  | rg Crematory 5-8-2  | 2008 Smithsb   | urg, MD  |  |  |  |
| Baltimore,                 | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medi-al Examiner must be notified at once. | Funeral Home<br>wn, MD 21742 |   |   |  |  |  |  |  |
| 2                          | -5-6   |                              | 23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  | nter the mode of dying, such as cardiac   | or respiratory arrest,   | Approximate<br>Interval Between                        |  |  |  |
|                            | Physician  |                              | Immediate Cause (Final disease or condition   | piratory Far  | 'hure  | Onset and Death  |  |  |  |
| *                          | /Medical<br>Examiner   |                              | resulting in death)  Due to (or as a consequence of):   | Pial Tutas  | c +:   | <i>5</i>   |  |  |  |
|                            |  | ē                            | if any, leading to immediate cause. Enter Underlying  | Jul   | 0,00   | ( Zes 1) any   |  |  |  |
|                            | outed id ansit   | Examine                      | that initiated events   | cy Aztery.  | ) isease   | Several Hor  |  |  |  |
| ó,                         | cate be executed oblysician and the burial-transit   |                              | resulting in death) Last  Due to (or as a consequence of):  | ma of her   | my   | Coursed um   |  |  |  |
| 38760,                     | death certificate be executed<br>e attending physician and<br>d for use as the burial-transit  | dical                        | d   | 7   |  |  |  |  |  |
| Box 6                      | leath certific<br>attending p<br>I for use as  | Physician/Me                 | IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy 1 □ Live birth 2 □ Fetal death 3  | DEstania pragnancy  |  | ate of delivery  |  |  |  |
|                            | death  | sicia                        | in the past 12 months?  1  Yes 2 No  No   | ☐ Ectopic pregnancy ☐ Other (specify)   | M  | onth Day Year  |  |  |  |
| P.0                        | at the<br>d by th<br>etache  | Phy                          | 9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.   | 23e. Did tobacco use cor   | stribute to the cause of death?                        |  |  |  |
|                            | w requires that the deben signed by the should be detached   | d by                         |   |   | 1 XYes 2 □ No  | 3 Probably 4 Unknown                                   |  |  |  |
| COL                        | w req  | Completed                    | Diabeter Mellitus<br>Hypertension   |   |  | Were autopsy findings available                        |  |  |  |
| Re                         | i <b>clan</b> : The law<br>certificate has b<br>ector, page 2 sh   | ошо                          |   |   | autopsy<br>performed?<br>1 Yes 2 do  | prior to completion of cause of death?  o 1 ☐ Yes 2 No |  |  |  |
| /ita                       | ysician:<br>is certifica<br>director, p  | Be C                         | 25. Was case referred to medical examiner?  | Othor   | th (Check only one)  |  |  |  |  |
| or/                        | dir ys   | 2                            | 1 Yes 2 Hospital: 1 Impatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time   |   | ome 5 Residence 6 Of 28d. Describe how injury occur                                |  |  |  |  |
| on                         | Attending I<br>r death.<br>ector: After<br>by the funer  | tion                         | 1 Defaural 5 Pending (Month, Day Year) Injury 2 Accident investigation  |   | , ,  |  |  |  |  |
| Division or Vital Records, | or Attendated death Director:  | Certification:               | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, s building, etc. (Specify)  | street, factory, office   | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)    |  |  |  |  |
| _                          | To the Hospital or Attending Ptwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral   | edical Co                    | 29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.  | ath occurred at the time, date and place<br>investigation, in my opinion, death occ   | e, and due to the cause(s) and n<br>urred at the time, date and place              | nanner as stated.<br>e, and due to the cause(s)        |  |  |  |
|                            | To the within 2 To the comple  | Med                          | 201 0: 1 100 -1 0:00 -1   | 29c. License number   | 29d. Date sign   | ed (Month, Day, Year)                                  |  |  |  |
|                            | ->-0   |                              | > [ Aladerus  | 1035497   | 5-0  | 3 - 58   |  |  |  |
| . 1                        | lua ( i  |                              | 30. Name and address of person who completed cause of death (Item 23a) (Type  | D35497  | H28000.LL  | n. MB2171  |  |  |  |
| J)/                        | 47+1   | oto                          | 31. Date filed (Month, Day, Year) 32: Relistrar's Signature   |   | Jers Jos   | 10 -1 (8   |  |  |  |
|                            | St<br>Regist   | ate<br>rar                   | MAY 1 5 2008  | A TOP AND A STATE OF THE ADDRESS OF |  | •  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Wendy Sue Gutekunst 2008 1950 May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 303 Frederick St. Hagerstown Washington County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Months Days Year 44 Nov.9,1963 **Director** 381-76-3062 Michigan Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Medical Examinar is not by notified at 1 Yes 2 No Director Maryland Washington County Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 303 Frederick Street 21740 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within D partment of Health and Mental Hyglene. Important: If item 27 is marked other than any Injury or other traumatic event, the Magnets. Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Clothing Mfg. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Ernest Gutekunst Judy Ann Balch Gutekunst 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri M. Plumer-sister 303 Frederick St. Hagerstown, <u>MD 21740</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 5-10-2008 | Smithsburg, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral 1331 Eastern Blvd. North Hagerstown, MD 21742 Kaillin. 23a. Part 1. Enter the diseas. , r corp cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cervical disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely illied in by the funeral director, page 2 should be detached for use as the burlat-transit completely illied in by the funeral director, page 2 should be detached for use as the burlat-transit resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 ☑No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month. Dav. Year) 04/66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 341-6 Medical Cormoule 31. Date filed (Month, Day, etrar's Signature State Registrar MAY 1 5 2008

DHMH 17 Rev 1/2001

Box 68760.

P.0.

of Vital Records.

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 08 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month MAY **Physician** Gene Herbert Giddings 2008 02:50  $A^{M}$ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON 8. Date of Birth (Month, Day, Aug. 21, 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Months Hours 220-30-2094 1 X M 2 □ F 73 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryia Department of Heath and M. ntal Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f shov any injury or other traumati event, the Medical Extra Instructs by the Internal 1 ☐ Yes 2X No Director New Freedom PA York 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? U.S.A. 17349 39 Singer Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 X Married ltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Steelworker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Redmond Herbert Giddings 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
39 Singer Rd., New Freedom, PA 17349 19a. Informant's Name/Relationship (Type. Print) Linda L. Giddings, Wife 20b. Place of Disposition (Name of cemetery, crematory or other pl Cremation Direct Service 20a. Method of Disposition 20c. Location - City or Town, State Date or other place) 1 ☐ Burial 2 【X Cremation 3 【X Removal from State May 20, 2008 York, PA 17401 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J.J. Hartenstein Mortuary, Inc. 21. Signature of Funeral Service Licensee El Mer Much 24 Second St., New Freedom, PA 17349 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 3hrs disease or condition resulting in death) Lesons toch /Medical Due to (or as a consequence of): **Examiner** VIASTISV. LUN Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed RUNcate has been signed by the attending physician and page 2 should be detached for use as the burial-transit POR CINOM Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 Other (specify) I∐Yes 2□No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 211No 1 ☐ Yes 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Whatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

7

31. Date filed (Month, Day, Year)

2

Charles

701

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2008

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 10 800 Lula Pauline Harman 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Garrett Oakland Nursing and Rehabilitation Center Oakland 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex Months Hours 1 □ M 2 🗙 F Aug. 8, 1918 Pennsylvania 89 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 X No Garrett Accident 10f. Zip Code 10g. Citizen of What Country? 21520 USA 2245 Cove Rd. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Havner Lula Faucett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 85 Devil's Half Acre Rd., Accident, MD Linda M. Strider/P.R. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 12, 2008 Accident, MD St. John's Cemetery 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service Licer Climas P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lafture. List only one cause on each line. Months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 25€No 1 ☐ Yes 2√2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

permit. Pages 1 and 2 should be filed within 72 hours eftar deeth with tha Maryland Department of Haalth end Mental hygiene. Important: if them 27 is marked other than "natural", or itema 23e or 28e-f ahow eny injury or other treumatic event, the Medical Examinar must be notified at Baltimore, Maryland 21215-0020 Physician /Medical Examiner or Attending Physician: The lew requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, daeth. To the Hoapital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the f

Be Completed by Physician/Medical Examiner

Medical Certification: To

Physician

/Medical

Examiner

Funeral

Director

5. Social Security Number

236-58-0980

10e. Street and Number

12

Immediate Cause (Final disease or condition resulting in death)

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 - Homicide

29b. Signature and title of certifier

11. Marital Status

10a. State

Director

Be Completed by Funeral

State Registrar

H0064705 e and address of person who completed cause of death (Item 23a) (Type, Print)

Richard A. Porter, 311 N. 4th Street, Oakland, MD 21550

31. Date filed (Month, Day, Year) MAY 1 4 2008 32. Registrar's Signature 29c. License number

29d. Date signed (Month, Day, Year)

|        |                                 |   |                 | 1 - For<br>State<br>Registrar  | State of  | Marylan                                |                                 | irtment of F<br>tificate of                 | lealth and M<br>Death                        |  | leg. No.                             | 18 17286   |
|--------|---------------------------------|---|-----------------|--|---|--|---------------------------------|---|--|--|--------------------------------------|--|
|        |                                 | Physici   |                 | Decedent's Name (First, Middle, La   |   | Evelyn H                               | lash                            |   |  | 2. Date of Dea<br>Month<br>May             | Day                                  | 3. Time of Death<br>10:05 a M  |
|        |                                 | /Medio<br>Examin  |                 | 4a. Fecility Name (If not institution, given   | e street and nun  | nber)                                  |                                 | 4b. City, Town, o                           | or Location of Death                         |  | 4c. County of                        |  |
|        |                                 |   |                 | Harford Memor  | ial Hosp  | ital                                   |                                 | Havre                                       | de Grace                                     |  |                                      | Harford  |
|        |                                 | Funeral<br>Director   |                 |  | Gex<br>I□M 21X0F  | 7. Age (In yrs. i<br>74                | ast birthday)<br>Yrs.           | If Under 1 Year<br>Months Days              | If Under 24 Hrs.<br>Hours Min.               | 8. Date of Birth<br>(Month, Day<br>Feb. 11 | (, Year)                             | 9. Birthplace (State or Foreign<br>Country)<br>West Virginia                       |
|        |                                 | and w   |                 | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. City                              | . Town or Lo                    | cation                                      |  |  |                                      | 10d. Inside City Limits  |
|        |                                 | Maryi<br>f eho  | ō               | Maryland Ceci  | 1   |  |                                 | Rising                                      | Sun  |  |                                      | 1 ☐ Yes 2 ☒ No   |
|        |                                 | r 28a   | Director        | 10e. Street and Number   |   |  |                                 | 10f. Zip Code                               |  | 1  | 10g. Citizen of W                    | /hat Country?  |
| 3      |                                 | th with   | a D             | 18 Foxboro Drive   | 9   |  |                                 |   | 21911  |  | U                                    | .S.A.  |
| A.M    |                                 | r dea   | Funeral         | 11. Marital Status   | 12. Was Dece<br>Armed For   | dent Ever in U.                        | S. 13. V                        | Vas Decedent of H<br>Yes, specify Cub       | lispanic Origin? (Span, Mexican, Puerto      | ecify Yes or No-<br>Rican, etc.)           | 14. Race<br>Black                    | - American Indian,<br>c, White, etc.   |
| 0,05   | 21215-0036                      | permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Depertment of Heatth and Mental Hygiene. Important: if item 27 ie marked other then "naturel", or iteme 23a or 28a-f ehow eny injury or other treumatic event, the Medical Examinal must be notified at once. | þ               | 1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced   | 1 ☐ Yes<br>If Yes, Giv<br>Year or Da  | е                                      |                                 | ☐ Yes 215 No                                | Specify:                                     |  | Specify:                             |  |
| ,      | 5-0                             | 72 ho<br>natur<br>Jical   | eted            | 15. Decedent's E<br>(Specify only highest gr   | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during me |  |                                 |   |  |  | 16b. Kind of Bus<br>V.A. Ma          |  |
| 0      | 121                             | within<br>ene.<br>then "  | Be Completed    | Elementary/Secondary (0-12) Twelve Years   | College (1  | -4or 5+)                               |                                 |   | <sup>d)</sup><br>Operator                    |  | Healthc                              | are System<br>oint, Maryland   |
|        |                                 | filed<br>Hygi<br>other  | Ö               | 17. Father's Name (First, Middle, Last   | )   |  |                                 |   | 18. Mother's Name                            | e (First, Middle,                          |                                      |  |
|        | ylan                            | Mental<br>Mental<br>Brked<br>atic ev  | 10 B            | Rus  | sell Ho   | lcomb                                  |                                 |   | S  | usan V.                                    | Carpent                              | er   |
| 0.0    | Baltimore, Maryland             | nd 2 shall lith and 27 ie m   |                 | 19a. Informant's Name/Relationship Caroline Parrett  |   | hter)                                  |                                 |   | and Number or Run<br>rive, Ris.              |  | -                                    |  |
| 2/1/08 | ore,                            | of Hea  |                 | 20a. Method of Disposition 1 <sup>™</sup> Burial 2 □ Cremation 3 □   | Removal from S  |  | lace of Disposemetery, crem     | sition (Name of<br>natory or other pla      |  | Date                                       | 20c. Location - 0                    | City or Town, State  |
| 1      | Him                             | it. Pages<br>ortment of l<br>ortant: if its<br>njury or o   |                 | 4 ☐ Donation 5 ☐ Other (Special Signature) of Funeral Service Lice   | y) (  | Wes                                    |                                 | ngham Cemet                                 |  | 10/08                                      | Colora,                              | Maryland   |
| 0      | Ba                              | permit. Depertrimports eny inje   |                 | 21. Signature di Pullerai Service Lice   | A COU   | BOOK                                   | _ / L                           | Name and Addre<br>ee A. Pa<br>erryvill      | tterson &<br>e, Maryla                       | Son Fur<br>nd 2190                         | neral Ho<br>03-0766                  | me, P.A.   |
| MU     |                                 | Physician<br>/Medical<br>Examiner   | <u>.</u>        | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions | a. Due to (o  | ach line.                              | DIRATE                          | 1   | ng, such as cardiac o                        | or respiratory are                         | est,                                 | Approximate<br>Interval Between<br>Onset and Death                                 |
|        | 68760,                          | ificate be executed<br>g physicien end<br>as the burial-transit   | edical Examiner | Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last              | c   | or as a consequ                        |                                 |   |  |  |                                      |  |
|        | Box                             | law requires that the death certifi<br>as been signed by the ettending<br>2 should be detached for use as   | Iclan/M         | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  |   | rth 2 ☐ Fetel<br>ant at time of de     | death 3 [                       | Ectopic pregnancy<br>Other (specify)        | <b>,</b>                                     |  | 23d. Date<br>Mon                     | e of delivery<br>tth Day Year  |
|        | s, P                            | res that<br>igned b<br>be deta  | by Phys         | Part II. Other significant conditions  | contributing to de  | ath but not resu                       | ılting in the un                | derlying cause giv                          | ren in Part I.                               | 23e. Did to                                |                                      | bute to the cause of death?  |
|        | ord                             | w require<br>been si<br>should t  | ted             |  |   |  |                                 |   |  | 1 🗆 Y                                      | es 2/S/No                            | 3 Probably 4 Unknown   |
|        | Division of Vital Records, P.O. | The hite h  | Completed       |  |   |  |                                 |   |  | 24a. Was a autop: perfor 1 Yes             | sy pr<br>med? de                     | Vere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☑ No |
| 3      | ita                             | ysician: The<br>is certificate hi<br>director, page   | Bec             | 25. Was case referred to medical examiner?   |   |  |                                 |   | 26. Place of Deati                           | 100  |                                      |  |
| A      | >                               | Physic<br>this ce<br>al dire  | 2               | 1 ☐ Yes 2 No   | Hospital: 1 1 Ir  | npatient 2                             | ER/Outpatient                   | 3□ DOA O#                                   | er: 4 Nursing Ho                             | me 5 ☐ Resid                               | ence 6 Othe                          | or (Specify)   |
| 1      | ion o                           | ng<br>fter<br>iner  | atlon:          | 27. Manner of Death 1 XNatural 5 ☐ Pending 2 ☐ Accident investigation  |   | f Injury<br>h, Day Year)               | 28b. Time of<br>Injury          | 28c, Injui<br>Wor<br>M 1                    | yat<br>rk?<br>Yes 2 □No                      | 28d. Describe h                            | ow injury occurre                    | ed   |
| lAsh,  | Divis                           | f or Attend<br>efter death<br>Director: A<br>in by the f  | Certification;  | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place  | of Injury - At ho<br>ig, etc. (Specify | me, farm, stre                  | et, factory, office                         |  | 28f. Location (S<br>City or Tow            |                                      | er or Rural Route Number,  |
| Ï      | _                               | To the Hospitel or Attendi<br>within 24 hours effer death.<br>To the Funeral Director: A<br>completely filled in by the fu  | Medical C       | 29a. Certifier (Check unity one)  1. Certifying Pl 2   Medical Example   | nysician: To the<br>miner: On the ba<br>and mann  | isis of examinat                       | wledge, death<br>ion and/or inv | occurred at the tile<br>estigation, in my o | me, date and place,<br>opinion, death occurr | and due to the cred at the time, c         | ause(s) and mar<br>late and place, a | nner as stated.<br>nd due to the cause(s)  |
|        | •                               | To th<br>within<br>To th<br>compi   | Me              | 29b. Signature and title of dertifier  | In Corn   | ( Med                                  | Hospit                          | DE Cons                                     | 136  |  | 05/13                                | (Month, Day, Year) 2 2 008   |
|        | 1                               | 2   |                 | 30. Name and address of person who Nnenna Uch  | completed cause   | of death (Item                         | 23a) (Type, I                   | Print)<br>IN AVE                            | HAVRE  | de GR                                      | Ace MC                               | 21078  |
|        |                                 | Sta   | te              | 31. Date filed (Month, Day, Year)  | 1/6/  | gistrar's Signa                        | ture                            | N.  |  |  | I was                                |  |

State of Maryland / Department of Health and Mental Hygiene 2008

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 1130 AM **Physician** Holst Ruth Eleanor 10 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Center Montgomery Brooke Grove Renabilitation and Nursing Sandy Spring
If Under 1 Year If Under 24 Hrs.

Plays Hours Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) Sep 03, 19 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 M 2 XF 1918 89 067-18-8401 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City. Town or Location 10a. State 10b. County ir than "natural", or Items 23s or 28s-f show The Medical Examinar must be nutitived at 1 Yes 2 No Sandy Spring Director Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20860 United States 1612 Hickory Knoll Road Funerai filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 N Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Education School Teacher . Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 is marked other taury or other treumatic event, it 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ruth Cramp George Newton 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18432 Flower Hill Way Gaithersburg, MD. 20879 item 27 l Marsha Tucker (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition May, 2008 1 □ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or once. Lakeside Cemetery Bernhards Bay, NY <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Licensee -STUVE TRACE! 10 East Deer Park Drive Gaithersburg, MD. 20877 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death hypercalcemia Immediate Cause (Final 1 month Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) one primary unknown Examiner b. Malignancy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Date to (or as a consequence of) Examine anding physician and use as the buriat-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death ned by the a should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 No this certificate Hospital or Attending Physicien: After this certification funeral director, 25. Was case referred to medical 26. Place of Death Check on one Be Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 10 2008 M.D. ATTENDING PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) School Road Sandy Grace Brooke Huffman, U.D. 18100 Slade 31. Date filed (Month, Day, Year) MAY 13 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 17288 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 4:31 A<sup>M</sup> Juanita Ross Harris May 9 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Suburban Hospital Bethesda Montgomery If Under 1 Year | if Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 ☐ M 2 耳F Vrs 405-26-0303 89 17, NC Nov. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show and injuly or other traumatic event, the Medical Examiner must be notified at once. 10d Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ▼No Director Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 9910 River Road 20854 United States Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Musician Self Employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Benjamin Ross Minnie Poteet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gerald R. Harris / Son 132 South Van Buren Street, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State May 10 2008 4 □ Donation 5 □ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Euneral Service Licensee DeVol Funeral HOme, 10 East Deer Park Drive, Gaithersburg, MD 20877 1RACI un 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End State Alzheimer Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed physician and s the burial-trans 43 Due to (or as a consequence of): Box 68760 Physician/Medical m as attending IF FEMALE: nse sa If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectonic pregnancy Month Year ğ Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.0. ☐Yes 2 No the detached 9☐ Unknown þ signed b d be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  $\subset$ Division or Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Dehydration Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page certificate 1 Yes or Attending Physician: 25. Was case referred to medical examiner? ector, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 XInpatient 2 ER/Outpatient 3 DOA ဥ this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After Iniury 1 XNatural 5 Pending In by the fune 1 ☐ Yes 2 ☐ No To the Hospital or Attendia within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier andra Delistathis MD D 59980 5/9/08 3:30pm. A. 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sandra Delistatuis , M.D., 8600 Old Georgetown Road, Bethesda, MD 20814 32 egistrar's Signature 31. Date filed (Month, Pay, Year) 2008 State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygier® \( \begin{align\*} \Omega \text{R} \\ \Omega \end{align\*} \)

17290

|                     |  |                     | 1- State of Maryland / Department of Health and Mer State Registrar  Certificate of Death  |                                      | Reg. No.                         | ) Q  | 1/209  |
|---------------------|--|---------------------|--|--------------------------------------|----------------------------------|--|--|
|                     | Physicia   | an                  | 1 Decedent's Name (First, Middle, Last) 2.   | Date of Dea<br>Month<br>May 1        | 4 Day 200                        | Year                                       | 3. Time of Death                                     |
|                     | /Medic   |                     |  | мау                                  | 4c. County                       |  | 12:10a м   |
|                     | Examin   | er                  | 4a. Fecility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  Julia Manor Nursing Center  Hagerstown   |                                      | Wash                             |  |  |
|                     | Funeral  |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Months Days Hours Min.   | Date of Birt<br>(Month, Day<br>-25-1 |                                  | 9. Birth                                   | place (State or Foreign ntry)                        |
| Н                   | Director   |                     |  | -25-1                                | 932                              | Cle  | ar Spring  |
|                     | and  |                     | Usual Residence of Decedent  10a. Slate 10b. County 10c. City, Town or Location  |                                      |                                  |  | 10d. Inside City Limits                              |
|                     | Maryl<br>-f sho  | tor                 | MD Washington Hagerstown   |                                      |                                  | i  | Yes 2□No   |
|                     | n the  | irec                | 10e. Street and Number 10f. Zip Code   |                                      | 10g. Citizen of \                | What Cou                                   | ntry?  |
|                     | 23a c  | ral                 | 333 S. Mill St. 21740  |                                      | U.S.Z                            |  | and la disc  |
| Maryland 21215-0036 | s filed within 72 hours atter death with the Maryland<br>I Hygiene.<br>other than "natural", or items 23a or 28a-f show<br>vant, the Medical Ever-it et med Le notified at | by Funeral Director | 11. Marital Status  1  Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes, Size Year or Dates:  13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric  | ty Yes or No-<br>can, etc.)          | Specify                          | <sub>y:</sub> white,                       | te   |
| 15-0                | "natu  | Completed           | 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   |                                      | 16b. Kind of B                   |  | /private   |
| 12                  | filed within<br>Hygiene.<br>ther than<br>int, the M  | dmo                 | Elementary/Secondary (0-12) 12th grade  College (1-4or 5+) nursing   |                                      | nospi                            | lais                                       | homes  |
| b                   | be filed<br>tal Hygid<br>d other<br>evant, L   | Be C                | 17. Father's Name (First, Middle, Last)  18. Mother's Name (F  | First, Middle,                       | Maiden Surnan                    | ne)  |  |
| ylaı                |  | 70                  | monas milata milis   |                                      |                                  |  | - 0-41   |
|                     | ind 2 should<br>alth and Men<br>27 is marks<br>ir traumatic  |                     | 19a. Informant's Name/Relationship (Type, Print) Richard L. Hovermale son  19b. Mailing Address (Street and Number or Rural R P.O. BOX 712 Fort As   |                                      | WV 267                           |  |  |
| Baltimore,          | Pages 1 and 2<br>nent of Health<br>int: if item 27 i<br>iry or othar tre   |                     | 20a. Method of Disposition  1  |                                      | Hager                            |  | own, State<br>wn MD                                  |
| Balti               | permit. Pag<br>Department<br>important: i<br>any injury o<br>once.   |                     | 21. Sonature of Piperal Service Licensee  22. Name and Address of Facility Donald Edwin Tho P. O. BOX 310 Clear  | mpsor                                | Funer                            | al :                                       | Home, Inc  |
|                     |  |                     | 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reshock, or heart tallure. List only one cause on each line.  | espiratory a                         | rrest,                           |  | Approximate<br>Interval Between                      |
|                     | Physician  | 8 1                 | disease or condition Chron. Cobstructive   | hun                                  | n Di                             | Sec.                                       | Onset and Death                                      |
|                     | /Medical<br>Examiner   |                     | resulting in death)  Due to (or as a consequence of):  |                                      |                                  |  |  |
|                     |  | er                  | Sequentially list conditions,  |                                      |                                  |  |  |
|                     | cuted<br>Id<br>ransit  | Examiner            | Sequentially list conditions, if any, reading to limitediate cause. Enter Underlying Cause (Disease or injury that initiated events)   |                                      |                                  |  |  |
| 30,                 | tificate be executed<br>ig physician and<br>as the burial-transit  |                     | cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  | tuc                                  | >                                |  |  |
| 68760,              | cate b<br>physic<br>the b  | ledical             | d  |                                      |                                  |  |  |
| Box.                | ath cer<br>ittendir<br>or use  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   |                                      |                                  | ate of deliventh                           | very<br>Day Year                                     |
| , P.O               | that the de<br>ned by the a<br>detached t  | by Ph               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did t                           | obacco use con                   | tribute to                                 | the cause of death?                                  |
| rds                 | w requires to been signer should be  | ed b                |  | 10                                   | Yes 2 □ No                       | 3 □ Pro                                    | obably 4 Donknown                                    |
| I Records,          |  | Completed           | <u> </u>   | 24a. Was<br>auto<br>perfo<br>1 ☐ Yes | psy<br>ormed?                    | Were aut<br>prior to c<br>death?<br>1  Yes | topsy findings available completion of cause of 2 No |
| Vital               | Physician: Th<br>this certificate<br>ral director, pag   | Be                  | 25. Was case referred to medical examiner?  Hospital: Classical 25. PDA Other: 4. Clas |                                      |                                  |  |  |
| of                  | Phys<br>this<br>ral di   | To !t               | 27. Manner Death 28a. Date of Injury 28b. Time of 28c. Injury at 28  |                                      | dence 6 ∐Oti<br>how injury occu  |  | ity)   |
| ion                 | こう をき  | atior               | 1 ☑Natural 5 ☐ Pending (Month, Day Year) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No  |                                      |                                  |  |  |
| Division            | al or Attendi<br>s efter death.<br>Il Diractor: A<br>id in by the fu   | Certification;      | 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   | 8f. Location (<br>City or To         | Street and Num<br>wn, State)     | ber or Ru                                  | ral Route Number,                                    |
|                     | To the Hospital or At within 24 hours effer of To the Funeral Diract completely tilled in by   | Medical C           | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  | d due to the<br>d at the time,       | cause(s) and m<br>date and place | anner as<br>, and due                      | stated.<br>to the cause(s)                           |
|                     | To the To the Comp   | Σ                   | 29b. Signature and title of certifier  29c. License number  D 0 6 0 3 9 6  |                                      | 29d. Date sign                   |  |  |
| •                   |  |                     | The state of the s |                                      | 05/1                             | 7 10                                       | ~  |
| 14                  | H-1  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   | ~ c                                  | 1740                             |  |  |
|                     | Sta  | ite                 | 31. Date filed (Month, Day, Year)  32. Registrar's Signature   | ) =                                  | 1170                             |  |  |
|                     | Regist   |                     | MAY 1 5 2008   |                                      |                                  |  |  |

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Erwin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner COUNTY Hospita NOERSTOWN WASHING TON HSHINGTON HELL Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Days Hours Min. 10 **Director** 218-34-2737 April 1,1938 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event; the Medical Examiner must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland | Washington County Smithsburg 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21940 Holiday Drive 21783 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 [7]Yes 2 [1] 56— Year or Dates: 1960 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Equipment Operator Aluminum Mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Hebb Frances Fisher Hebb ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy I. Hebb-wife 21940 Holiday Dr. Smithsburg, MD 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Beaver Creek Cemetery: 5-15-2008 | Smithsburg, Maryland 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 lugh 23a. Part1. Enter the diseast, or com- cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause the each line. Immediate Cause (Final disease or condition resulting in death) **Physician** DOV /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying sician and burial-transit physician 23d. Date of delivery Year Day o use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, been signed be should be deta To the Hospital or Attending Physician:

Baltimore, Maryland 21215-0036

| that initiated events resulting in death) Last  | c   |  |
|---|---|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown | 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)  | 23d. Date of delivery  Month Day Yea   |
| Part II. Other significant conditions   | s contributing to death but not resulting in the underlying cause given in Part I.  | 23e. Did tobacco use contribute to the cause of deat 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unk                         |
|   |   | 24a. Was an autopsy findings ava prior to completion of caus death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No                |
| 25. Was case referred to medical examiner?  | 26. Place of D  | Death (Check only one)   |
| 1 Yes 2 No  | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing  | g Home 5 ☐ Residence 6 ☐ Other (Specify)   |
| 27. Manner Death 1  | 28a. Date of Injury / (Month, Day Year) 28b. Time of Injury Work?  M 1 ☐ Yes 2 ☐ No   | 28d. Describe how injury occurred  |
| 3 ☐ Suicide 6 ☐ Could not determine   |   | 28f. Location (Street and Number or Rural Route Number<br>City or Town, State)                                   |
| 29a. Certifier (Check only one) 1 Certifying 2 Medical Ex                               | Physiclan: To the best of my knowledge, death occurred at the time, date and pl<br>aminer: On the basis of examination and/or investigation, in my opinion, death o<br>and manner stated. | ace, and due to the cause(s) and manner as stated. occurred at the time, date and place, and due to the cause(s) |

and place, and due to the cause(s) within 2 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 17291 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** May 6, 7:23 P M Thomas Michael Johnson 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex 1 M 2 □ F If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11-8-1955 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days Hours Min Director 212-70-4137 52 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits show "natural", or items 23a or 28a-f shov edical Examiner must be notified at 1X Yes 2 □ No Director Maryland Anne Arundel **Annapolis** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with Innent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or ? 40 Heritage Ct. 21401 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ¼Yes 2 □ No If Yes, Give Year or Dates: 1977–97 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Corpsman U.S. Navv other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paul Cornelius Johnson Ellen Dorene Gray 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah A. Johnson/ Wife 40 Heritage Ct., Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Kalas Crematory 5-8-08 Edgewater, MD neral September 21. Signatu 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 11 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** espirat disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 I Inknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 1∐ Yes 2 100 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 10 1 ☐ Yes 1 Impatient 2 ER/Outpatient 3 DOA Certification: To Hospital or Attern..., 24 hours after death.

ne Funeral Director: After thi
...filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 atural Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the To the within ? To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00005829-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) selmedical Centr, Annapolis MD MD ound Year State MAY 0 9 2008

Registrar

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|---|-----------|------|----|
| State of Maryland / Department of Health and Mental | Hygiene 2 | 2008 | 1. |
| Cartificate of Death                                |           |      | •  |

|  | 1 - State Registrar C6   | artment of Health and Nertificate of Death  | Mental Hygiene 2008 1729   |
|--|--|---|--|
| Physician<br>/Medical  | 1. Decedent's Name (First, Middle, Last)  Elizabeth Walker Kilgore   | the City Town and another of Death  | 2. Date of Death Month Day Year 3. Time of Death Year 4c. County of Death  |
| Examiner<br>Funeral  | 4a. Facility Name (If not institution, give street and number)  Shady Grove Adventist Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | 4b. City, Town, or Location of Death    Rockville   | Montgomery  8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreig Country)   |
| Director   | 579-10-7180  |   | March 22,1920 Missouri   |
| Hygiene. ther than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at a Completed by Funeral Director   | Maryland Montgomery Gaither  10e. Street and Number  | rsburg<br>10f. Zip Code   | 1 ☑ Yes 2 ☐ No   |
| Department of Health and Mental Hygiene "natural" or items 23a or 28a-f show Important: if item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.  To Be Completed by Funeral Director   | 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:   | 20877 Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto            | Specity: White   |
| ygiene.<br>ner than "natur:<br>nt, the Medical I<br>tt, the Completed  | (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  2  F  | edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ounder | Literacy Council   |
| nd Mental Hy<br>marked oth<br>imatic event<br>To Be (  | 17. Father's Name ( <i>First, Middle, Last</i> )  Solon Mark Walker  19a. Informant's Name/Relationship ( <i>Type. Print</i> ) 19b. Mai  |   | e (First, Middle, Maiden Surname)  Serena Gertrude Orr ral Route Number, City or Town, State, Zip Code)  |
| of Hearn an  | Sharon K. Featherstone/Daughter 2542   | Logan Wood Drive,   |  |
| Department<br>Important: i<br>any injury o<br>onos.  | 4 □ Donation 5 □ Other (Specify) Ft. Linc  21. Signature of Funeral Service Licensee   | 22. Name and Address of Facility De   | /2008   Brentwood, Maryland<br>Vol Funeral Home<br>r., Gaithersburg, MD. 20877   |
| physician and street burial-transit see burial-transit and leading the burial-transit and leading the burial examiner and lead | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of in the property of that initiated events resulting in death) Last  Lymphoma  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of): |   | Months   |
| d by the attending ptetached for use as the Physician/Med  |  | □Ectopic pregnancy<br>□ Other (specify)   | 23d. Date of delivery  Month Day Year  |
| en signed by<br>uld be detacted<br>and by Ph   | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒Unkno   |
| cete has been s<br>age 2 should<br>Completed   |  |   | 24a. Was an autopsy performed? 1 ☐ Yes 2X No 124b. Were autopsy findings availa prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No |
| white it is the functal breator. After this certific te has been signed by the attending prompletely filled in by the funeral director, rage 2 should be detached for use as the completely filled in by the funeral director, rage 2 should be detached for use as the Medical Certification: To Be Completed by Physician/Med  | 25. Was case referred to medical examiner?  1  Yes 2 No  | ent 3 DOA Other: 4 Nursing Ho   | h (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred   |
| nous arier users.  neral Director: After filled in by the funer al Certification:  | 3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, s building, etc. (Specify)  29a. Certifier  1 ☑ Certifying Physician: To the best of my knowledge, dea  | ath occurred at the time, date and place  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) and due to the cause(s) and manner as stated.                           |
|  | (Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier   | nvestigation, in my opinion, death occu   | red at the time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  |
| 5  | 30. Name and address of person who completed cause of death (Item 23a) (Type   |   | May 6, 2008  |
| State<br>Registrar   | Steven Dolinsky, M.D., 911 Russell Av<br>31. Date filed (Month, Day, Year) 32. Registrar's Signature   |   | g, Maryland 20878  |

State of Maryland / Department of Health and Mental Hygiene 2008Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 2:16 P M Richard Allen Keehfus May 9, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8530 Harvest View Court Ellicott City Howard 8. Date of Birth (Month, Day, Year)
Feb. 17, 19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1XM 2□ F 1939 Director 108-30-3282 69 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show mit: If item 27 is marked other than "naturel", or items 23a or 28a-f show mit; If item 27 is marked other than "nature" or other traumatic event, the Medical Examiner must be notified at my or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 XNo Director Ellicott City MDHoward 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21043 8530 Harvest View Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Follows.

1 X Yes 2 No
If Yes, Give
Year or Dates: 1959-93 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: White Specify. ş 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Auto Parts Store Business Owner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ Berniece Korb Fredrick Casper Keehfus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kay W. Keehfus/wife 8530 Harvest View Court Ellicott City, MD 21043 permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 05/13/08 Beltsville, MD 21. Signature of Funeral Service Licen 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 23a. Part1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC PROSTATE **Physician** MONTHS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to in modate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Daw to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ ALZHEIMERS DISEASE 1 ☐ Yes 2 XNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 perform or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🖔 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 XNo Certification: To 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1064931 MA May 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) Registrar

32. Degistrar's Signature

DHMH 17 Rev 1/2001

DAVID COSGROVE, JOHNS HOPKINS HOSPITHE, GOD NORTH WOLFE STREET. BALTIMORE MD 21287

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Winfield LaVon 05 16 08 1210 Kennedy /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** WMHS Braddock Campus Cumber land Allegany If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days XXM 2□F Yrs. 194-16-4871 Director 83 9-2-1924 PA Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exemination. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director Bedford Hyndman 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 128 Adams St. PO Box 306 15545 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Ty Yes 2 □ No If Yes, Give Unk. Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0wner Auto Sales 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Franklin Kennedy Cleo B. Shaffer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mae Jean Kennedy 128 Adams St., PO Box 306 Hyndman PA 15545 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hyndman Cemetery 5-20-2008 Hyndman, PA 22. Name and Address of Facility Harvey H. Z eigler Funeral Home Inc 21. Signature of Funeral Service License 169 Clarence St. Hyndman PA 15545 le, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1 Enter the disease shock, or heart failuge. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hemorrhain Due to (or as a consequence ): \da disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown has been sign 2 should be 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes > No 24a. Was an autopsy performe certificate ha 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident (Month, Day Year) Injury 5 Pending investigation nerai Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 16,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cumberland 900 SETON Dr 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Alan. Α. Kistler May 9, 11:50p 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery 2503 North Gate Terrace Silver Spring If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 □xM 2 □ F 177-18-9123 87 Yrs. Director 1920 Pennsylvania Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State show r than "natural", or items 23a or 28a-f shov 1 ☐ Yes 2 TNo Director Maryland Montgomery Silver Spring with the I 10g. Citizen of What Country? 10e. Street and Number 20906 USA 2503 North Gate Terrace by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: WWT 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 21215-0036 1 □Yes 2 No Specify Specify: White 3 Widowed 4 ☐ Divorced WWII Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic event, the Mental or other traumatic events. Elementary/Secondary (0-12) College (1-4or 5+) Director of Org. & Field Services AFT-CTO Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Alan A. Kistler Margaret C. Ward 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Kistler Brown/Daughter 2503 North Gate Terrace, Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery May 15 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State d permit. Page Department ( Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 7 years 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure **Physician** /Medical Due to (or as a consequence of): Examiner 40 years Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed 40 years Hypertension burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ cate has been signal page 2 should b 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown Hypothyroid, Diabetes Mellitus Type II Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Atrial Fibrillation autopsy performed? 1 □ Yes 22 21No certificate funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) å examiner? Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1∐ Yes 2∐**X**No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation nours after death.

neral Director: / 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide thin 24 hours at Hospital 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) May 12, 2008 D39966 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Caroyin Hammett, MD 1835 University Blvd., East, #226, Langley Park, MD 20783 31. Date filed (Month Max Year 3 32. Resistrar's Signature State 2008

Registrar

|                            |  |                     | 1 - For<br>State<br>Registrar  | State of Man  |  | artment of I   |   | R  | eg. No.                                     |  |
|----------------------------|--|---------------------|--|---|--|--|---|--|---|--|
| ı                          | Physici<br>/Medic  |                     | 1. Decedent's Name (First, Middle, Last) Willis T. Kump  |   |  |  |   | 2. Date of Deat<br>Month<br>May              | Day Yea<br>12 200                           | 3. Time of Death 2:30 P M                                  |
|                            | Examir   | _                   | 4a. Fecility Name (If not institution, give s<br>Williamsport Nur  |   |  |  | or Location of Death                                  | 1  | 4c. County of De<br>Washing                 |  |
|                            | Funeral<br>Director  |                     | 5. Social Security Number 6. Sex 191–18–3279   | 7. Age (i   | n yrs. last birthday)<br>81 Yrs.         | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth<br>(Month, Day,<br>Apr 12,  | Year) 9.8                                   | irthplace (State or Foreign<br>Country)<br>PA              |
|                            | yland<br>how   |                     | Usual Residence of Decedent  10a. State 10b. County  | 1   | Oc. City, Town or Lo                     | cation   |   |  |   | 10d. Inside City Limits                                    |
|                            | the Ma   | ecto                | WV Berkeley  10e. Street and Number  |   | Falling W                                |  |   |  | On Citizen of 14th at 6                     | 1 Tyes 2 No  |
|                            | 23a or   | al Dir              | 253 Grade Road   |   |  | 10f. Zip Code<br>25419   |   |  | 0g. Citizen of What 0                       | ountry?  |
| 036                        | permit. Peges 1 and 2 should be filed within 72 hours eiter death with the Maryland Depertment of Heelih and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehow eny injury or other treumatic event, the Mudical Exantian must be notified at once.  | by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced   | 2. Was Decedent Eve<br>Agned Forces?<br>1 1 Yes 2 No<br>If Yes, Give<br>Year or Dates: 19 |  | Was Decedent of I<br>I Yes, specify Cub<br>I □ Yes 2 No                  | dispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or No-<br>o Rican, etc.)          | 14. Race - An<br>Black, Wh<br>Specify: W    | nite, etc.   |
| Maryland 21215-0036        | within 72 ho<br>ene.<br>then "natur<br>he Madical  | Completed           | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  |   | (Give                                    | dent's Usuaf Occup<br>kind of work done<br>DO NOT use retire<br>administ | during most of world)                                 | king   | 16b. Kind of Busines                        |  |
| and 2                      | d be filed<br>anta! Hygi<br>ced other<br>c event, I  | To Be Co            | 17. Father's Name (First, Middle, Last) Edgar R. Kump  |   |  |  | 7   | ne (First, Middle, M<br>Seyler               |   | carrey   |
| ary                        | and Mental<br>marked o   | F                   | 19a. Informant's Name/Relationship (Type   | oe, Print)  | 19b. Mailir                              | ng Address (Street   | and Number or Ru                                      | ral Route Number                             | , City or Town, State                       | Zip Code)  |
| e,                         | 1 and 2<br>1 deelth<br>1 m 27 l  |                     | Betty A. Kump w 20a. Method of Disposition   | ife   | P.O.                                     |  | Falling   |  | WV 25419<br>20c. Location · City of         | Taura Chata  |
| POE                        | Peges<br>nent of I<br>int: if Ite  |                     | 1 ☐ Burial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation 5 ☐ Other (Specify)  | amoval from State   | cemetery, crem<br>Cumberlan<br>Crematori | natory`or other pla  |   |  | Waynesbor                                   |  |
| Baltimore,                 | permit. Depertriction of the point of the po |                     | 21. Signature of Funeral Service License   | 9   | 22<br>M                                  | Name and Address 111er-Bo  | ess of Facility Werosx Fu                             | neral Ho                                     | me  |  |
| r'                         | Physician<br>/Medical  |                     | 23a. Part. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)            | sudder  |  | _  |   |  |   | ASTIC PA 1/22 Approximate Interval Between Onset and Death |
|                            | Examiner   | 5                   | Sequentially list conditions,  | Atherosc<br>Due to (or as a c   | lerotic Consequence of:                  | cardio v   | esculer   | Disease                                      | se.   |  |
|                            | ificate be executed<br>physicien and<br>as the burial-transit  | Examiner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last | Due to (or as a c   |  |  |   |  |   |  |
| 68760,                     | licate be<br>physicie<br>s the bur   | edical              | C  |   |  |  |   |  |   |  |
|                            | The law requires thet the death certif<br>ste has been signed by the ettending<br>page 2 should be detached for use a  | Physician/Me        | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 3c. If yes, outcome of p<br>1 ☐ Live birth 2 [<br>4 ☐ Pregnant at tim<br>9 ☐ Unknown      | Fetal death 3                            | Ectopic pregnanc   | у   |  | 23d. Date of d<br>Month                     | elivery<br>Day Year  |
| ds, P.                     | uires thet<br>signed by<br>Id be deta  |                     | Part II. Other significant conditions con  | tributing to death but r  |  | nderlying cause gr   | ven in Part I.  |  |   | to the cause of death?                                     |
| Division of Vital Records, | iicien: The law req<br>certificete has beer<br>rector, page 2 shou   | Completed by        |  |   |  |  |   | 24a. Was a<br>autops<br>perform<br>1 □ Yes 2 | ned? prior to<br>death?                     |  |
| N X                        | ysicier<br>s certif<br>directo   | To Be               | 25. Was case referred to medical examiner?  1  Yes 2 No  | ospital:  | 2 ER/Outpatien                           | t 3 DOA Ott  |   | th (Check only on                            | e)<br>ence 6 □Other (Sp                     | ecify)   |
| 0 00                       | Attending Physicien: It death. Sector: After this certified by the funeral director.   |                     | 27. Manner of Death 1. Natural 5 ☐ Pending   | 28a. Date of Injury<br>(Month, Day Y  | ear) 28b. Time of Injury                 | 28c. Inju  | ry at<br>rk?  |  | ow injury occurred                          |  |
| Division                   | To the Hospitel or Attending Physicien: The law within 24 burus after death. To the Funerel Director: Attenthis certificate has completely filled in by the funeral director, page 2   | Certification:      | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined  | 28e. Place of Injury<br>building, etc. (  | - At home, farm, str<br>Specify)         |  | Yes 2 □No   | 28f. Location (St.<br>City or Town           | reet and Number or I                        | Rural Route Number,  |
|                            | To the Hospitel or A within 24 hours after To the Funerel Dire completely filled in b  | edlcal (            | 29a. Certifying Phys<br>(Check only one)   | ician: To the best of n<br>er: On the basis of ex<br>and manner stated                    | amination and/or inv                     | occurred at the tivestigation, in my o                                   | me, date and place<br>opinion, death occu             | , and due to the ca<br>rred at the time, da  | ause(s) and manner<br>ate and place, and di | as stated.<br>ue to the cause(s)                           |
|                            | To the<br>within<br>To the<br>compl  | Me                  | 29b. Signature and title of certifier  | . ~   |  | 29c. Licens  | se number   | 25   | 9d. Date signed (Moi                        | 100  |
| 7                          |  |                     | 30. Name and address of person who cor   | mpleted cause of deat   | h (Item 23a) (Tyne                       | Print)   | 2/00  | \\\  | lay 15, Z                                   | 800  |
| St.                        | 1-12+1   |                     | TED E. HOWE  | 154 N. ART  | TR WAST                                  |  | MAPORT  | MD Z   | 1795  |  |
|                            | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year)  MAY 1 5 200   | 32. Registrar's   | Signature                                |  |   |  |   |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 11:43 AM M May 18, 2008 Hazel B. Layman /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany 12001 Emmettdale Lane, S.W. Shaft If Under 24 Hrs. Hours Min. If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 5 Social Security Number 6. Sex **Funeral** Months Days 1 M 2 X F 97 December 13, 1910 Maryland 214-80-4888 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c, City, Town or Location 10a. State 10b. County than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Shaft Maryland Allegany 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12001 Emmettdale Lane, S.W. U.S.A 21532-Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event the Medicine. 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: ģ 3 ₩Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) homemaker 12 homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie Smith Robert Brain ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21532-Maryland Paulette Coakley 12001 Emmettdale Lane Frostburg 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State May 21, 2008 Frostburg Maryland Frostburg Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licens Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Port. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) SENILE 6 MO **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dure to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 □Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ₹ No 4□Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an certificate has autopsy performed page 1 Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tyes 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Certification: To this 28d. Describe how injury occurred 28h Time of 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? After (Month, Day Injury or Attending 5 Pending investigation Natural n 24 hours after death.

Ie Funeral Director; Af
bletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who per: lux Cumber LAND, MD 21502 31. Date filed (Month, Day, Year) State

Registrar

1 9 2008

State of Maryland / Department of Health and Mental Hygien 2008

17298

|  |  |  |                              |   |   | Ce                       | rtificate                      | of       | Death                              |                        | F   | eg. No.                      |                          |  |                         |
|--|--|--|------------------------------|---|---|--------------------------|--------------------------------|----------|------------------------------------|------------------------|---|------------------------------|--------------------------|--|-------------------------|
|  | Physician  | Decedent's Name (First, Manager 1. Decedent's Name (First, Manager 1. Decedent's Name (First, Manager 1. Decedent's Name (First, Manager 1. Decedent's Name (First, Manager 1. Decedent's Name (First, Manager 1. Decedent's Name (First, Manager 1. Decedent) | fiddle, Last)                | Vir   | ginia                                   | ric                      |                                |          |                                    |                        | 2. Dete of Dea<br>Month                   | th Day V 07, 2008            | Year                     | 3. Time o                                    | of Death                |
|  | /Medical   | 4 = 100 44 44 44   |                              |   | tan Mon                                 | 115                      |                                |          | 4h City To                         | wo orlo                | ocation of Death                          | 4c. County                   |                          | U.   | 333                     |
|  | Examiner   | 4a Fecility Neme (If not instit  |                              |   | **                                      |                          |                                |          | -                                  |                        |   | 4c. County                   |                          |  |                         |
|  |  |  | legany (                     | County Nursin   |   |                          | - KIL-1                        | 1 1/     |                                    | umbe                   |   |                              |                          | gany   |                         |
|  | Funeral<br>Director  | 5. Social Security Number 218-24-8650  | 6. Sex<br>1 □                | м 2 <sup>3</sup> Д F                                    | (In yrs. last                           | t birthday,<br>Yrs.      | Months                         | Days     |                                    | Min.                   | 8. Date of Birth<br>(Month, Day<br>August | Yeer)<br>05, 1928            | Coun                     | lace (State<br>try)<br>Marylar               |                         |
|  |  | Usual Residence of Deceder   | nt                           |   |   |                          |                                |          |                                    |                        |   |                              |                          |  |                         |
| Aarylan  | r show<br>ed at  | 10a. State 10b. Co   | unty<br>Alleg                | anv   | 10c. City, T                            | own or L                 | ocation                        |          | Cumbe                              | rland                  |   |                              | 1                        | 0d. Inside C                                 | City Limits<br>s 2 □ No |
| 94   | ect es   |  | Ance                         | arry  |   |                          | 10f. Zip                       | Codo     | Cumoc                              | Tariu                  |   | 10g. Citizen of \            | What Cour                | itry?  |                         |
| h with t   | 23a or 28a-f s<br>at be notified<br>al Director  | 10e. Street end Number   | 20 Frede                     | erick Street  |   |                          | 101. Zip                       | 0000     | 2150                               | )2                     |   | rog. Onizorror               | US.                      |  |                         |
| deal   | E E E  | 11. Marital Status   | 1                            | 2. Was Decedent E                                       | ever in U,S.                            | 13.                      | Was Decede                     | ent of I | Hispanic Or                        | igin? (Sp              | ecify Yes or No-<br>Rican, etc.)          | 14. Rad                      | e - Americ<br>ck, White, |  |                         |
| 5-0020<br>72 hours efter death with the Maryland   | "natural", or tems 23a or 28a-f show<br>edical Examiner must be notified at<br>leted by Funeral Director | 1 □ Never Married 2 □ 3 □ Widowed 4 □ Divo   |                              | Armed Forces? 1 ☐ Yes 240 N If Yes, Give Year or Dates: | lo                                      |                          | 1 ☐ Yes 2                      | 11       |                                    |                        | radan, oto.                               | Specify                      |                          |  |                         |
| <b>9</b> 2   | F 5  |  |                              |   |   | I Sa Dece                | dent's Usual                   | I Occur  | nation                             | _                      |   | 16b. Kind of B               | usiness/In               | White  | 3                       |
| 2 2  | le de le   | (Specify only h  | edent's Educ<br>ighest grade | completed)  |   | (Give                    | kind of work                   | k done   | during mos                         | t of work              | ing                                       | 102. 74.10                   |                          | ,  |                         |
| Baltimore, Maryland 21215-0020<br>permit. Pages 1 and 2 should be filed within 72 hours eft    | than the M   | Elementary/Secondary (0-   | 12)                          | College (1-4or 5-                                       | +)                                      | 1110.                    | DO 1401 US                     |          | Secretar                           |                        |   |                              | Gla                      | ISS  |                         |
| ם ₫  | d other<br>event, t  | 17. Father's Name (First, Mic  | ddle, Lest)                  |   |   |                          |                                |          | 18. Moth                           | er's Name              | e (First, Middle,                         | Maiden Suman                 | ne)                      |  |                         |
| <u>а</u>   | Mental marked on matic ev  |  | Ţ                            | loyd Newmar   | n                                       |                          |                                |          |                                    |                        |   | Mary Neff                    |                          |  |                         |
| ary<br>shout   | d Men<br>narke<br>natic  | 19a. Informant's Name/Rela   |                              |   |   | 19h Mail                 | ing Address                    | (Stree   | and Numb                           | er or Rur              | al Route Numbe                            |                              |                          | Code)  |                         |
| Ma<br>2 s  | Isr  |  |                              |   | 1                                       | IOD. IVIAII              | ing Addiese                    |          |                                    |                        |   |                              |                          |  |                         |
| ano  |  | Thomas   | Jacobs                       | - Friend  | ani Di                                  | 4 Dina                   | anitian (Man                   |          | rost Av                            | enue,                  | Frostburg,                                |                              |                          |  |                         |
| ore<br>es 1  | if of Heal   | 20a. Method of Disposition 1 ■ Burial 2 □ Cremat   | ion a l'Ita                  | amount from State                                       | 20b. Plac                               | etery, cre               | osition (Namematory or ot      | her pla  | ace)                               | į                      | Date                                      | 20c. Location                | City or 10               | WII, State                                   |                         |
| Pages  | ry of  | 4 □ Donation 5 □ Other   |                              | emoval from State                                       | Roc                                     | kv Ga                    | p Vetera                       | ns C     | emeters                            | , !                    | May 12,<br>2008                           | Flint                        | stone                    | Marylar                                      | nd                      |
| alti   | Departm<br>Importai<br>any Inju<br>once  | 21. Signature of Funeral Ser   | vice License                 | e   | 1100                                    | -                        | 2. Name and                    |          |                                    |                        |   | n-McKen                      |                          |  |                         |
| <b>m</b> 8   | Q F 2 9  | 1 Sun 5  | Mils                         | 0   |   |                          |                                | 8        | 8 East M                           | lain St                | treet Lona                                |                              |                          |  |                         |
|  |  | 23a. Part1 Enter the diseas  | e. or convoli                | cations that caused                                     | the death.                              | Do not en                | ter the mode                   |          |                                    |                        |   |                              | 1                        | Approxima<br>Interval Be                     | ate                     |
| /1   | ysician<br>Medical<br>caminer  | shock or heart failure.  Immediate Cause (Final disease or condition resulting in death)   | a                            | Chron   | Due to (or a                            |                          |                                |          | Tilm                               | Jung                   | Disco                                     | re                           |                          | Onset and                                    | Death                   |
| 77   | ē  |  |                              |   |   |                          |                                |          |                                    |                        |   |                              | 1                        |  |                         |
| ox 68760,<br>certificate be executed   | iding physician and use es the bunal-transit   | Sequentially list conditions   | <b>6</b> b                   |   | Due to (or a                            | s a conse                | equence of):                   |          |                                    |                        |   |                              |                          |  |                         |
| ,<br>exec  | n an<br>ial-tr   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  |                              |   | , |                          |                                |          |                                    |                        |   |                              | Ì                        |  |                         |
| 9  | sicia<br>bun   | Cause (Disease or injury   | 0                            |   | - · · ·                                 |                          |                                |          |                                    |                        |   |                              | -                        |  |                         |
| <b>68760,</b> ificate be ex  | g physicia<br>es the bur<br>ledical  | resulting in death) Last   | 1                            | ·   | Due to (or as                           | s a conse                | quence or):                    |          |                                    |                        |   |                              | 1                        |  |                         |
| OX 6   | ding<br>use es   |  |                              |   |   |                          |                                |          |                                    |                        |   |                              |                          |  |                         |
|  |  |  |                              |   |   |                          |                                |          |                                    |                        |   |                              |                          |  |                         |
| dea  | ned by the atter<br>detached for u   | Part II. Other significent cor   | nditions con                 | tributing to death bu                                   | ıt not resulti                          | ng in the                | underlying ca                  | ause gi  | iven in Part                       | l.                     | 23b. Did                                  | obecco use co                | ntribute t               | the cause                                    | of deeth?               |
| P.O.   | by #   |  |                              |   |   |                          |                                |          |                                    |                        | 1页  | Yes 2□ No                    | 3 ☐ Pro                  | bably 4                                      | Unknow                  |
| tha tha  | gned<br>be de<br>by F  |  |                              |   |   |                          |                                |          |                                    |                        |   |                              |                          |  |                         |
| Division of Vital Records, P.O. Bo<br>lor Attending Physician: The law requires that the death | cate hes been signed be page 2 should be detailed.   |  |                              |   |   |                          |                                |          |                                    |                        | 24a. Was<br>perfo                         | an autopsy<br>rmed?          | a۱                       | ere autopsy<br>ailable prior<br>impletion of | r to                    |
| a ec   | hes by<br>ye 2 st<br>mple  |  |                              |   |   |                          |                                |          |                                    |                        |   |                              | of                       | death?                                       |                         |
| Ž P  | ate he<br>page<br>Com  |  |                              |   |   |                          |                                |          |                                    |                        | +1.11                                     | 65 2 No                      | - 11                     | ⊒Yes 2[                                      | □ No                    |
| <u>.</u> <u>.</u>  |  | 25. Was case referred to me  | dical                        | -   |   |                          |                                |          | 26 Plac                            | e of Deat              | th (Check only o                          |                              | 1                        |  |                         |
|  |  | examiner?  |                              | ospital:  |   |                          |                                | . 01     | 1.9                                |                        | ome 5□Resi                                |                              | or (Coosi                | 6.1)   |                         |
| of Vita<br>Physician:  | ± = ⊢  | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death  |                              | 1 ☐ Inpatie   |   | 3/Outpatie<br>3b. Time ( | 1000                           |          |                                    | ursing no              |   | now injury occu              |                          | <b>y</b> /                                   |                         |
| E E  | h.<br>After<br>funer   | 1 Natural 5 P  | ending                       | (Month, Day   | Year)                                   | Injury                   |                                | 8c. Inju |                                    | late.                  | Zod. Dosoribo                             | ion injury cood              |                          |  |                         |
| VISION   | death.<br>Stor; A<br>y the fi  | 2 Accident   | vestigation                  |   |   |                          | М                              | 1        | Yes 2                              | INO                    |   |                              |                          |  |                         |
| OIVIS<br>or Att  | rs after death.  al Director; After t ied in by the funera  Certification;                               |  | ould not be<br>etermined     | 28e. Place of Inju-<br>building, etc                    |   | e, farm, s               | treet, factory                 | , office | •                                  |                        | 28f. Location (<br>City or To             | Street and Num<br>vn, State) | ber or Rur               | al Route Nu                                  | imber,                  |
| Hospital   | within 24 hours after death To the Funeral Director: completely filled in by the Medical Certificat      | 29a. Certifier 1 Certifier (Check only one)  | tifying Phys<br>lical Examir | inian: To the best of                                   | examination                             | n and/or in              | th occurred a<br>nvestigation, | at the t | time, date <i>a</i><br>opinion, de | nd place,<br>ath occur | and due to the<br>red at the time,        | cause(s) and m               | anner as s               | tated.<br>o the cause                        | e(s)                    |
| ş  | thin 2<br>the maple  | -  | $\Lambda$                    | and manner sta  |   |                          | 20-                            | Licon    | nse number                         |                        |   | 29d. Date signe              | ed (Month                | Day Year                                     | )                       |
| 10   | Co Co  | 29b. Signature and title of ce   | runer                        | 1 /   |   |                          |                                |          |                                    | Co                     |   |                              |                          |  |                         |
|  |  | h  | my-                          | frus  |   |                          |                                | 10       | 0352                               | - 40                   | nbeclano                                  | May "                        | 1, 20                    | 0 8  |                         |
| ,  |  | 30. Name and eddress of pe   | rson who co                  | mpleted cause of de                                     | eath (Item 2                            | 3e) (Type                | , Print)                       |          |                                    |                        |   | V                            |                          |  |                         |
|  | 1  | Da Sucili  | 6                            | oto M   | 4 (                                     | 24                       | KONL                           | Au       | 100110                             | Cin                    | nhorlon                                   | MACI                         | ilmi                     | 1 21   | 1502                    |
|  |  | 21 Pate fled (Month Carl   | - DUG                        | 20 Paris  | A L                                     |                          | CICI                           | / \V     | ciuc                               | , whi                  | TACING (                                  | 1,100                        | Torch                    | 4/5/   | VVU                     |

Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydien 2008

|   | - State<br>Registrar   |  | Department of Health an<br>Certificate of Death  | d Mental Hygien                         | 2008 17299   |  |  |
|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | Decedent's Name (First, Middle, Last)     Stan  4a. Facility Name (If not institution, give st.)   |  | Miller  4b. City, Town, or Location of D   | May 7, 2                                | ay Year 3. Time of Death 2:25 P M  |  |  |
| Funeral Director  | WMHS— Braddock Can 5. Social Security Number 6. Sex  |  | Cumberland  rthday) If Under 1 Year   If Under 24  |   | Allegany  9. Birthplace (State or Foreign Country)  Black Oak, MD                                      |  |  |
| g   | Usual Residence of Decedent  | 10c. City, Tov   |  |   | 10d. Inside City Lim<br>1 ☐ Yes 2 🔀  |  |  |
| oath va 23s   | 10e. Street and Number  948 Beachy Rd  11. Marital Status  1□ Never Married 2 ★ Married  | 2. Was Decedent Ever in U.S.<br>Armed Forces?<br>1 ∐Yes 2 ☑ No   | 10f. Zip Code  21520  13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F  | ? (Specify Yes or No-                   | SA  14. Race - American Indian, Black, White, etc.   |  |  |
| al Hygiene al Other than "natural", or item vent, the Medical Examinat.  Be Completed by Fun.                           | 3 Widowed 4 Divorced  15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)   |  | Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) | working                                 | Specify: White Kind of Business/Industry   |  |  |
| Mental Hygien Mental Hygien Metal other the stic avent, the   | 7 17. Father's Name (First, Middle, Last) Cletus L. Miller   |  |  | Name (First, Middle, Maide<br>Mae Lough | esort<br>en Sumame)  |  |  |
| f Health and I<br>f Health and I<br>flam 27 le ma<br>other trauma   | 19a. Informant's Name/Relationship (Type A. Yvonne Miller/Wi 20a. Method of Disposition  | fe 9   | A8 Beachy Rd., Acc  Of Disposition (Name of  | ident, MD 2                             | v or Town, State, Zip Code)  1520  Location - City or Town, State                                      |  |  |
| permit. Pages Department of I Important: If its any injury or or once.  | 1 Mag Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  | Dawso  | n Cemetery May  22. Name and Address of Facility  P.O. Box 275, Gr                           |   | al Homes, P.A.   |  |  |
| Physician<br>/Medical<br>Examiner   | 23a, Part 1. Enter the disease, or comblic shock, or heart ailure. List only one Immediate Cause (Final disease or condition resulting in death)   | ations that caused the death. Do cause on each line.  A o A  Due to (or as a consequence                         | not enter the mode of dying, such as ca  | rdiac or respiratory arrest,            | Approximate<br>Interval Between<br>Onset and Death   |  |  |
| ean betinicate be executed attending physician and for use as the burial-transit clan/Medical Examiner                  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a consequence  | <u> </u>   |   |  |  |  |
| d by the attending phetached for use as the Physician/Medi  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown                | n 3 □Ectopic pregnancy<br>5 □ Other (specify)  |   | 23d. Date of delivery<br>Month Day Year  |  |  |
| certificate has been signed by the rector, page 2 should be detached by Be Completed by Physic                          | Part II. Other significant conditions control  | ibuting to death but not resulting   | in the underlying cause given in Part I.  Apple Timesen                                      | 1 ☐ Yes                                 | o use contribute to the cause of death?  2  No 3 Probably 4 Unknow  24b. Were autopsy findings availab |  |  |
| this certificate he ral director, page  | 25. Was case referred to medical examiner?   | spital:  | 10.  | autopsy performed?  1 Yes 2 12 1        | No 1 Yes 2 No  |  |  |
| this ral di   | 1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not be determined  | 28a. Date of Injury (Month, Day Year)  28b.  28e. Place of Injury - At home, f                                   | Time of Injury M 1 Yes 2 No  | 28f. Location (Street                   | jury occurred  and Number or Rural Route Number,   |  |  |
| within the hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification. | 29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine  | building, etc. (Specify)  cian: To the best of my knowledger: On the basis of examination are and manner stated. | e, death occurred at the time, date and photor investigation, in my opinion, death           | occurred at the time, date a            | (s) and manner as stated. Indiplace, and due to the cause(s)   |  |  |
| with Total  | 29b. Signature and title of certifier    Signature and title of certifier   Signature and address of person who comes are the signature and address of person who comes are the signature and title of certifier   Signature and t | My Wash (Item 23a)   | (Type, Pript)  | 0/                                      | Date signed (Month, Dey, Year)  5/8/8  EN R.   |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)  | 32. Régistrar's Signature  | Oakland, und   | , 51220 K                               | Buczyjuský mo  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 008

Certificate of Death Reg. No. 17300

Physician /Medica Examine

1 \_ For State

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

|  |   | o (r not) mad  | , 2001)  |  |  |  |  |  |  |   | - 1                                   | N. 6 1 fo   | D  | ay.  | Voor   | 1   |                                  |
|--|---|--|--|--|--|--|--|--|--|---|---------------------------------------|---|--|--|--|---|----------------------------------|
| an   | 1. Decedent's Name Tena S   | Sue 1  | Moyer  | r  |  |  |  |  |  |   |                                       | Month<br>05/  | o,   | 6°/ 20   | $008^{\text{Year}}$  | 12:1  | 7 P                              |
| al<br>er   | 4a. Facility Name (/  |  |  |  | number)  |  |  | 4b. City                                     | , Town, or   | r Location of   | Death                                 | -   | 4  | c. County  | y of Death   | )   | -                                |
|  | 4136 Mar  | yland  | High   | hway   |  |  |  | 0ak:   | land   |   |                                       |   |  | Garre  | ett .  |   |                                  |
|  | 5. Social Security N  |  | 6. Sex   |  | 7. Age   | (In yrs. la  | Months Days Hours Min. (Month, Day, Year)  |  |  |   |                                       |   |  | Cot  | place (State<br>Intry)   | e or Fo   |                                  |
|  | 219-50-5  |  |  | 1101 2231  |  | 61   |  |  |  |   |                                       |   |  | Mar  | aryland  |   |                                  |
| - H  | Usual Residence of<br>10a. State  | 10b. Count   | y  |  | 1  | 10c. City,   | Town or L  | ocation                                      |  |   |                                       |   |  |  |  | 10d. Inside   | City Lir                         |
| ţ  | MD  | Garr   | 0+t  |  |  |  | 0  | 0akland                                      |  |   |                                       |   | 1 ⊡Yes 2⊠  |  |  |   |                                  |
| Director   | 10e. Street and Nu  |  | CCC  | _  |  |  |  |  | ip Code  |   |                                       |   | 10g. 0   | Citizen of   | What Co  | untry?  |                                  |
| a  | 4136 Mai  | ryland   | Hig  | hway   |  |  |  | 2  | 1550   |   |                                       |   |  | US   |  |   |                                  |
| Funeral  | 11. Marital Status  | _  |  | 12. Was De<br>Armed F  | ecedent Ev<br>Forces?  | er in U.S.   | . 13   | Was Dece<br>If Yes, spe                      | edent of H<br>ecify Cub  | lispanic Origi<br>an, Mexican,  | n? (Spe<br>Puerto l                   | cify Yes or<br>Rican, etc.)   | No-  |  | ce - Amer<br>ck, White   | ican Indian,<br>, etc.  |                                  |
| by Fu  | 1 ☐ Never Marr<br>3 ☑ Widowed   |  |  | 1 ☐ Yes<br>If Yes, 0<br>Year or  | s 2 <b>⊠</b> No<br>Give<br>Dates:  | )  |  | 1 ☐ Yes                                      | 2 🔀 No   | Specify:  |                                       |   |  | Specif   | fy: W  | hite  |                                  |
| q pa   | 3 M Widowed   | 15. Decede   |  |  | Dates.   |  | 16a. Dec   | edent's Usi                                  | ual Occup  | ation   |                                       |   | 16b.   | Kind of B  | Business/I   |   |                                  |
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| mo:  |   | th   |  | Odliege  | (1-401 51)   | Teachers Assistant   |  |  |  |   |                                       | Во  | ard  | of E   | ducat:   | Lon   |                                  |
| Be C   | 17. Father's Name   | (First, Middle   | e, Last)   |  |  |  |  |  |  | 18. Mother  |                                       |   | _  |  | me)  |   |                                  |
| 2  | Lester  | Sp   | ring   | ·<br>!   |  |  |  |  |  | Ali   |                                       |   | 'Con   |  |  |   |                                  |
|  | 19a. Informant's N  |  |  |  |  |  |  |  | ,  | and Number  |                                       |   |  |  |  | ip Code)  |                                  |
|  | Amy C.  |  | / Da   | ughte  | r  | 20h Pia  |  | Kyans  |  | e, Swa  |                                       | ate   |  |  |  | Town, State   |                                  |
|  | 1 🗌 Burial 2  | ⊠Cremation   |  | lemoval from   | m State  | cei  | metery, ci   | ematory or                                   | r other pla  | 1   |                                       |   |  |  | •  |   |                                  |
|  | 4 □ Donation  21. Signature of Fi   |  | -  | . \  |  | Ome  |  | remat<br>22. Name a                          |  | ess of Facility   |                                       | /2008   |  |  |  |   |                                  |
| r d  | 1 R   | 10   | TX.  | 1  | \  |  |  |  |  | econd   |                                       |   |  |  |  |   |                                  |
|  | 23a. Part1. Enter 1   | the disease,   | or compli  | iontions the   | anunad t   |  |  |  |  |   |                                       |   |  | ,,,,,  |  | Approxin  | nate                             |
|  | shock, or hea   |  | or combi   | icalions ina   | ii causeu i  | ne death.  | Do not e   | nter the mo                                  | ode of dyi   | ng, such as c   | ardiac c                              | or respirator   | y arrest,  |  |  | Interval I  | RATWAR                           |
| 1  | Immediate Cause   | art failure. Li:<br>(Final   | st only or   | ne cause or  | n each line  | ð.   |  |  |  |   | ardiac c                              | or respirator   | y arrest,  |  | 0.0  | Interval I<br>Onset ar  | nd Deat                          |
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| edical Certification: To Be Completed by Physician/Medical | Immediate Cause disease or condition resulting in death)  Sequentially list or farmer of the cause. Enter Under Cause (Disease or that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1  | int pregnant 2 months?  The mon | itions conditions conditions directly and the string of th | Due to Du | to (or as a to (or | conseque conseque conseque conseque f pregnan f   Fetal   lime of de t not resul ry - At hor (Specify, f my know examinatifed.   | oma we ence of):  ence | ent 3 Confirment and occurred investigation. | pregnanc (specify)   | 26. Place her: 4 \( \triangle \) Nur imp at imp, date an opinion, deat se number      | of Death                              | 23e. D  1  24a. V  a p  1   Ye  Check or  me SES  28d. Descri  28f. Locatic  City or  and due to  red at the ti   | id tobacc  Yes  Vas an utopsy erformed ses 2\(\frac{\text{S}}{2}\)  In the causime, date  29d.   | Moo use cor 2 No 24b 24b 2 No 4 G Or and Num are) 24c 24c 25c 26c 26c 26c 26c 27c 27c 27c 27c 27c 27c 27c 27c 27c 27 | pate of del Month  Intribute to  Intribute   | onset and 4 mon.  4 mon.  ivery Day  the cause obably 4 stopsy finding completion of 2 No.  cify)  ural Route No. | Year  Year  Unkrigs ava  di caus |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Rosalie Elizabeth Miller May 21, 2008 2038 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WMHS-Memorial Campus Allegany Cumberland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/21/1922 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Min 1 □ M 2 🗓 F 86 215-18-8170 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental hygiene.

ant: If item 27 is marked other than "natural", or Items 23a or 28a-f show 10d Inside City Limits 10c. City. Town or Location 10a State 10b. County 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1X☐Yes 2☐No MD Allegany Cumberland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21502 USA 811 Hampton Place Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify ρ White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Shanholtzer Leasure Jessie Howard Ausburn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health an Important: If item 27 Is any injury or other trau once. 601 Sylvan Avenue, Cumberland, Maryland 21502 Margaret C. Leasure / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐Removal from State Cumberland Crematory 05/22/2008 Cumberland, MD 4 □ Donation 5 □ Other (Specify) 21. Sign jure of Funeral Service Licens 22. Name and Address of Facility Adams Family Funeral Home, F.A. 21502 404 Decatur Street, Cumberland, MD 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 000 **Physician** /Medical Due to (or as a consequend of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) physician a Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day Vear in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 (Month, Day Year) Injury 5 Pending investigation 1 Natural within 24 hours after com...

To the Funeral Director: After a state of the funeral by the funeral filled in by the funeral funeral filled in by the funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral funeral functions for the funeral funeral functions fun 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner spated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar Afaq Ahmad, M.D.,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

D0060478

904 Seton Drive, Cumberland, Maryland

May 22, 2008

Certificate of Death

2. Date of Death

Мау

 $12^{\text{Day}}$ 

2008<sup>a</sup>

Calvert

Wash.

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3907 Chesapeake Beach Road Chesapeake Beach Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-11-1938 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F Director 214-34-6920 70 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10b. County Director MD Chesapeake Beach Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3907 Chesapeake Beach Road 20732 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give <sup>1</sup>⁄<sub>Y</sub> Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) public school teacher education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Maybelle Griffith George Frankenfield Livings 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6639 Brookside Court, Bealeton, VA 22712 Joseph G. Livings, brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 5/14/2008 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 M No 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24a. Was an After this certificate has autopsy performed res 2 No 1□ Yes To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No ပို 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature a of certi 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

M.D.,

2008

1. Decedent's Name (First, Middle, Last)

Maybelle

McIntyre

Louise

**Physician** 

/Medical

3. Time of Death

3:44 P M

Birthplace (State or Foreign Country)

D.C.

10d. Inside City Limits

Approximate Interval Between Onset and Death

YEAR

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 ☐ No

Year

Month

1 ☐ Yes

1 TYYes 2 □ No

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person Charles Judge,

31. Date filed (Month, Day, Year)

110 Hospital Rd., Ste. 310, Prince Frederick, MD 20678

|            |  |                | 1 - For<br>State<br>Registrar  | State   | of Maryla  | •                           | artment of<br>rtificate of                               | Health and<br>Death                              | d Mental F                              | lygien<br>Reg. N                        | e 20(                                | 8 (       | 17303  |
|------------|--|----------------|--|---|--|-----------------------------|--|--|---|---|--------------------------------------|-----------|--|
|            | Physici  | an             | 1. Decedent's Name (First, Middle  |   |  |                             |  |  | 2. Date of<br>Month                     |   |                                      | ear       | 3. Time of Death                                   |
|            | /Medic   | cal            | Martin Jay  4a. Facility Name (If not institution  | Molk  | number)  |                             | 4h City Town   | or Location of De                                |   | 11,                                     | 2008<br>c. County of                 | Death     | 7:55 a <sup>M</sup>                                |
| £          | Examin   | ner            | 3908 Brooke M  |   |  |                             | Oln  |  | sau i                                   |   | ,                                    |           | gomery   |
|            | Funeral<br>Director  |                | 5. Social Security Number 219-42-3639  | 6. Sex<br>1. ■ M 2. F                         |  | rs. last birthday)<br>Yrs.  | If Under 1 Yea<br>Months Days                            |  | in. (Month,                             | Day, Yea                                | 9<br>19 <b>46</b>                    | Count     | ace (State or Foreign<br>try)<br>shington, D       |
|            | pul 🔉  |                | Usual Residence of Decedent  10a, State 10b, County  |   | 100  | City, Town or Lo            | cation   |  |   |   |                                      | 110       | d. Inside City Limits                              |
|            | Maryla<br>f sho  | jo             | Maryland   | Montgo  |  | Olne                        |  |  |   |   |                                      | "         | 1 ∐ Yes 21€0Xlo                                    |
|            | r 28a-   | Directo        | 10e. Street and Number   | mon ego.                                      | mery   | OIII                        | 10f. Zip Code  |  |   | 10g. (                                  | Citizen of Wha                       | at Count  | ry?  |
|            | th with  |                | 3908 Brooke  | Meadow L                                      | ane  |                             | 20   | 832  |   |   | US                                   | A         |  |
| 350        | rs after death with the Maryland<br>I", or items 23a or 28a-f show<br>mainer must be notified at   | by Funeral     | 11. Marital Status  1 □ Never Married XX Mar  3 □ Widowed 4 □ Divorced   | ried Armed                                    | ecedent Ever in<br>Forces?<br>s 2 <b>∑x</b> No<br>Give<br>r Dates: |                             | Was Decedent of<br>If Yes, specify Cu<br>1 □Yes 2 🕦 No   | Hispanic Origin?<br>ban, Mexican, Pu<br>Specify: | ' (Specify Yes or<br>Jerto Rican, etc.) | No-                                     | 14. Race -<br>Black, \<br>Specify: 1 | White, e  | tc.  |
| 212-0036   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lury or other traumatic event, the Mudical Examinar must be notified at once. | Completed      | 15. Deceder<br>(Specify only higher<br>Elementary/Secondary (0-12)   | it's Education<br>st grade complete           |  | (Give                       | dent's Usual Occ<br>kind of work don<br>DO NOT use retir | e during most of v                               | working                                 | 16b.                                    | Kind of Busin                        | ess/Ind   | ustry  |
| 7          | led wi<br>Hygier<br><b>her th</b><br>nt, the   |                | 17. Father's Name (First, Middle,  | 5+  |  | Doc                         | tor of P   | odiatric   | Medici                                  |   | Healt                                | h Ca      | ire  |
| yland      | d be fi<br>ental F<br>ked ot<br>c evel   | o Be           | Jack Molk  | Lasty   |  |                             |  |  | Sutton                                  | ine, maide                              | en oumame)                           |           |  |
| ary        | should Mark  | ပ              | 19a. Informant's Name/Relations  | ship (Type. Print)                            |  | 19b. Mailir                 | ng Address (Stree  | et and Number or                                 |   | mber, City                              | y or Town, Sta                       | ate, Zip  | Code)  |
| Ž,         | and 2<br>ealth a<br>n 27 ls  |                | Kathleen Molk  | /Wife   |  | 390                         | B Brooke   | Meadow   | Lane, O                                 |   |                                      |           |  |
| ore        | ges 1<br>If iter<br>or oth   |                | 20a. Method of Disposition<br>1 ☐ Burial 2 🔀 Cremation   | 3 ☐ Removal fro                               | m State  | •                           | natory`or other pi                                       | · · · · · ·                                      | May 12,                                 |   | Location - Cit                       |           |  |
| Saltimor   | it. Pay<br>rtmen<br>rtant:<br>njun   |                | 4 Donation 5 Other (S  | *       | M  | -                           | itan Cre   | 1 -  | 2008                                    |   |                                      | ria,      | Virginia   |
| n<br>D     | Derm<br>Depa<br>Impo<br>any I  |                | 21. Signature of Funeral Service   | Oal   |  | -                           |  | ress of Facility<br>• Collin<br>rsity Bl         |   |   | ome Inc                              | ring      | , MD 20901   |
|            | Physician  |                | 23a. Part1. Enter the disease, o<br>shock, or heart failure. List<br>Immediate Cause (Final<br>disease or condition              | only one cause or                             | n each line.   | eath. Do not ent            |  | ying, such as card                               | diac or respirator                      | y arrest,                               |                                      | 1         | Approximate<br>Interval Between<br>Onset and Death |
|            | /Medical<br>Examiner   |                | resulting in death)  | Due   | to (or as a cons   | equence of):                |  |  |   |   |                                      |           |  |
|            | Lxammer  | er             | Sequentially list conditions,  | b   | ertensi<br>to (or as a cons  |                             |  |  |   |   |                                      | -         |  |
|            | uted<br>d<br>ansit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Emer Underlying Cause (Disease or injury that initiated events | •   |  |                             |  |  |   |   |                                      |           |  |
| 6/00,      | icate be executed<br>physician and<br>the burial-transit   | dical Exa      | resulting in death) Last   | d.  | to (or as a cons   | equence of):                |  |  |   |   |                                      |           |  |
| 9          | ertifica<br>ing ph   | Medi           | IF FEMALE:   |   |  |                             |  |  |   | 2                                       |                                      |           |  |
| O. BOX     | To the Hospital or Attending Physician: The law requires that the death certific thin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as              | Physician/Me   | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 ☐ Liv                                       | outcome of pre-<br>ve birth 2 Fe<br>egnant at time<br>oknown       | etal death 3                | Ectopic pregna<br>Other (specify)                        |  |   | _                                       | 23d. Date of<br>Month                |           | ry<br>Day Year                                     |
| ecords, P. | e law requires that the de<br>has been signed by the a<br>e 2 should be detached f   | þ              | Part II. Other significant conditi<br>Congestive Hea   | ons contributing to<br>rt Failu               | death but not or   | resulting in the u          | nderlying cause o  | jiven in Part I.                                 |   |   |                                      |           | e cause of death?                                  |
| o Heco     | The law re<br>ate has bee<br>page 2 sho  | Completed      |  |   |  |                             |  |  | pe                                      | /as an<br>utopsy<br>erformed?<br>s 2 ⊠1 | prio<br>dea                          | or to cor | osy findings available inpletion of cause of       |
| VII        | iclan:<br>sertific<br>ector,   | Be             | 25. Was case referred to medica examiner?  |   |  |                             | 10   |  | Death (Check on                         | -                                       | '                                    |           |  |
| 5          | ding Physiclan: The h.<br>h.<br>After this certificate h.<br>funeral director, page  | J.             | 1 ☐ Yes 2 ☑ No<br>27. Manner of Death  |   | Inpatient 2  | ER/Outpatier                | it 3 🗆 DOA   |  | g Home 5 ☑ R                            |   | 6 ☐ Other jury occurred              | (Specify  | )  |
| SION       | th.<br>th.<br>After  | tion           | 1 ☑ Natural 5 ☐ Pendir<br>2 ☐ Accident investi   | ng (M   | onth, Day, Year  |                             | W  | ork?<br>□Yes 2□No                                | 200. Descri                             | Je now in                               | july occurred                        |           |  |
| DIVIS      | To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the  | Certification: | 3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern  | inod     286. Pla                             | ce of Injury - A<br>ilding, etc. (Spe                              | t home, farm, str<br>ecify) | eet, factory, office                                     | )  | 28f. Locatio<br>City or                 | n (Street<br>Town, Sta                  | and Number<br>ate)                   | or Rura   | l Route Number,                                    |
|            | e Hospitt<br>124 hours<br>e Funera<br>sletely fille  | edical C       |  | ng Physician: To<br>Examiner: On the<br>and m |  |                             |  |  |   |   |                                      |           |  |
|            | Vithii<br>Comp   | Me             | 29b. Signature and title of certifie   | 05/   |  |                             | Į.   | nse number                                       |   | 29d. (                                  | Date signed (/                       | Month, I  | Day, Year)   |
|            | 16   |                | HON  | X   | - A  | >                           | D4   | 1245   |   |   | May 12                               | 2, 2      | 008  |
|            | ,  |                | 30. Name and address of person   | ain MD  | 1081   | 0 Connec                    |  | venue, K   | Censingt                                | on, N                                   | MD 2089                              | 95        |  |
|            | Sta<br>Registr   |                | 31. Date filed (Month, Day, Year)  | 3 2008 32                                     | . Registrar's Sig  | gnature                     | bert   |  |   |   |                                      |           |  |

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MAY **Physician** 2008 4:00 PM GOLDEN HORTENSE MAYBERRY 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner MONTGOMERY Holy Cross Hsopital Silver Spring If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 SAF Jan. 4, 1926 82 Virgînia Director 227-32-9467 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It's Madical Examinar must be notified at 1 ☐ Yes 2 No Director MDMontgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with 20905 U.S.A. 2244 Countryside Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc 72 hours after 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Black \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Fmployee 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I be filed within 7: intal Hygiene. ed other than "n U.S. Dept of Elementary/Secondary (0-12) College (1-4or 5+) Employee Commerce vrs Development Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental h Catherine P. Vincent William E. Young ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health tem 27 i Charles E. Mayberry (Husband) 2244 Countryside Dr, Silver Spring, MD permit. Pages 1 and Department of Health Important: If item 27 any Injury or other the 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Cremation 3 ☐Removal from the company of the co reensville Mem Cem 5/14/08 Emporia, VA 5 ☐ Other (Specify) 21. Signature Funeral Service Lic 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or com-shock, or heart failure. Ust only not enter the mode of dying, such as cardiac or respiratory arrest, ations that caused the death. br complic e cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorragic Stroke /Medical Due to (or as a consequence of) Examiner <u>Cerebralatherosclorosis</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off that the death certificate be executed and Due to (or as a consequence of) physician a Box 68760, Physician/Medical as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 3 Ectopic pregnancy Year for Month Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a □Yes o σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, g 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? The law 24a. Was an has \$2 s autopsy performed? page certificate 2**X** No 1 ∐Yes 1 ☐Yes 2 ☐No rector, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) After this c funeral dire 1 ∐Yes 2 ∐Wo 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation after death. 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 5/8/08 D63343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, MD 20910 Irina/Ruban, M.D. 32. Registrar's Signature MAY 13 31. Date filed (Month, State 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND TITH#24a, 25, per HYS., 08/8, 5/28/08, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Patricia Ann Macindoe May 18. 2:15 p 2008 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5526 Cedar Grove Rd. East New Market Dorchester 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birth Pay, Year)

26, 1942

9. Birthplace (State or Foreign Country)

Amage 1942

Maryland 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 F **Director** 216.40.3620 66 Feb. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Pres 2 No Directo Maryland Talbot Trappe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3892 Harrison Circle 21673 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Legal Secretary Law 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Herbert Mills Lula Elizabeth Phillips 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert John Macindoe/Spouse PO Box 608, 3892 Harrison Circle, Trappe, MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oxford Cemetery 5.22.2008 Oxford, Maryland Signature of Funer Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, 308 High St., Cambridge, MD 2 Approximate Interval Between Onset and Death rt1. Enter th Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician mas /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an s certificate has t lirector, page 2 s autopsy performed?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Noth Daughter's Home 1 ☐ Yes 2 📉 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manyler of Death 1 ☑ Natural Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29b. Signature and title of 29d. Date signed (Menth, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. David H. Smith, 29466 Pintail Dr., Easton, MD 21601

State Registrar 31. Date filed (Month, Day, Year)

MAY 2 8 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

|                   |   |                 | State of Maryland / Department of Health and Mental Hygiene  - State Registrar  State of Maryland / Department of Health and Mental Hygiene  - Certificate of Death  - Reg. No. 2008   17306   |
|-------------------|---|-----------------|--|
|                   | Physicia  |                 | 1. Decedent's Name (First, Middle, Last)  OFER GEORGE  ON ONE  2. Date of Death Month Day OF OF 13 / U M   |
|                   | /Medic<br>Examin  | 40.0            | 4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center  4b. City, Town, or Location of Death Annapolis  4c. County of Death Anne Arundel  |
|                   | Funeral<br>Director   |                 | 5. Social Security Number 053-01-4934  6. Sex 17. Age (In yrs. last birthday) 17. M 2   F   94   Yrs.  7. Age (In yrs. last birthday) 18. Days   Hours   Min.   Min |
|                   | Maryłand<br>-f show<br>ied at   | tor             | Usual Residence of Decedent  10a. State  |
|                   | with the 3a or 28a st be notif  | al Director     | 10e. Street and Number 524 Rita Dr.  10f. Zip Code 21113  USA  USA   |
| 036               | pormit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral      | 11. Marital Status  1  |
| 21215-0036        | vithin 72 ho<br>ine.<br>:han "natur<br>e Medical I  | Be Completed    | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+) 5+  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  US Army  |
| and 5.            | d be filed v<br>ental Hygie<br>ced other t<br>c event, th   | To Be Co        | 17. Father's Name (First, Middle, Last) Pasquale Nardone  18. Mother's Name (First, Middle, Maiden Surname) Conchetta Silento  |
| Maryland          | nd 2 shoul<br>alth and M<br>27 is marl<br>r traumatl  | Ĕ               | 19a. Informant's Name/Relationship (Type. Print) Beth Nardone Daughter  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Rita DR. Odenton, MD 21113   |
| Baltimore,        | Pages 1 a<br>nent of Hea<br>int: If item<br>iry or othe   |                 | 20a. Method of Disposition  1 \( \mathbb{Z}\) Burial 2 \( \subseteq \) Cremation 3 \( \subseteq \) Removal from State 4 \( \subseteq \) Donation 5 \( \subseteq \) Other (Specify) \( \subseteq \) Arlington National \( \subseteq \) 20b. Place of Disposition (Name of cemetery, crematory or other place) \( \subseteq \) 7/22/2008 \( \alpha \) Arlington, VA  |
| Balti             | permit. Departn Importa amy Inju  |                 | 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A.  12 Ridgely Ave. Annapolis, MD 21401  |
|                   | Physician<br>/Medical<br>Examiner   |                 | 23a. Part 1. Enter the disease, or o implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of)  Due to (or as a consequence of):  Due to (or as a consequence of):   |
| 38760,            | icate be executed physician and the burial-transit  | edical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.   |
| .O. Box 6         | The law requires that the death certific<br>te has been signed by the attending p<br>age 2 should be detached for use as  | Physician/Me    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown   9   Unknown   9   Unknown   9   23d. Date of delivery   23d. Date of delivery   23d. Date of delivery   Month   Day   Year    |
| <u>α</u>          | quires that<br>n signed b<br>uld be deta  | þ               | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes   2   No   3   Probably   4   Unknown  |
| or Vital Records, |   | Completed       | 24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No   |
| r Vite            | yslcian: The is certificate hadirector, page  | o Be            | 25. Was case referred to medical examiner?  1   Yes 2   No   |
| o uo              | ding Ph<br>J.<br>After th<br>funeral  | tion: T         | 27. Manner of Death  1 Natural 5 Pending (Month, Day Year)  1 Accident investigation  28a. Date of Injury 28b. Time of Injury 4 Work?  1 Yes 2 No  |
| Division          | al or Atten<br>after deatl<br>I Director:<br>d in by the  | Certification:  | Accident investigation  3 Suicide 4 Homicide   |
|                   | To the Hospital or Attenwithin 24 hours after death To the Euneral Director: completely filled in by the  | edical C        | 29a. Certifier (Check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |
| )                 | To # within   | )               | 29b. Signature and title of cartifier  29c. License number  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  |
|                   | W. W  | *               | 30. Name and address of person the completed cause of death (Item 23a) (Type, Priet) DEFENSE HOHWAY AND POUR MAZKEN  |
|                   | St<br>Regist  | ate<br>rar      | MAY 1 2 2008  Signature  MAY 1 2 2008  MAY 1 2 2008  |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 11:25 AM 8 2008 May Alex Eugene Nave /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County 635 Washington Ave. Hagerstown If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
May 2,1944 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (State or Foreign Country) Social Security Number 6. Sex 1 ☐ M 2 ☐ F **Funeral** Min. Hours 213-42-1318 64 Maryland Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 21740 635 Washington Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Types 24 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1□Yes 2█No White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Completed by 3 Widowed 4 Divorced "natural" th and Mental Hygiene.
7 is marked other than "natur traumatic event, Its Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Furniture Mfg 9 Deliveryman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Ellen Metz Nave Alex Bradley Nave 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a If item 27 is or other trau 635 Washington Ave. Hagerstown, MD 21740 Donna Nave-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If it any injury or conce. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 5-14-2008 Williamsport, Maryland Greenlawn Cemetery 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses Kaitt 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** manyh disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 Yes 2 🔲 No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No certificate has b autopsy performed? funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 □Yes 2 □No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide DECertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6H-3 1130 Opal Court, Hagerstown, MD 21740 Hind Hamden, MD strar's Signature 31. Date filed (Mont State 5 2008 Registrar

State of Maryland / Department of Health and Mental Hygien 2008

1 - State RegistAMEND#8, perFH, 5/13/08, DPS, McCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yee **Physician** 4:01 AM 2008 OWENS 5 KNIGHT DELINE /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTGOMERY KOCKVILLE ROCKVILLE N. HOME 8. Date of Birth3-25-1916 9. Birthplece (State or Foreign (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 F Yrs. -Massachusetts 2 Director 220-38-1465 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10b. County 10c. City. Town or Location 10a State ral, or itams 23a or 28a-f ahow Exprinter rough be notified at 1 ☐ Yes 2 ♣ No Director Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with U.S.A. 3340 Gleneagles Drive, #2D 20906 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter of Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itan any injury or other traumetic event, the Medical Examinist Once. 1 Never Married 2 Married I □Yes 2 X No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify À If Yes, Give Year or Dates: Caucasian 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Church Secretary 1 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Blynn Holwill Joseph Hyde Knight 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1515 Woodman Avenue, Silver Spring, Maryland 20902 Ethel O. Jorgensen - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State Fort Lincoln Crematory 05/16/2008 Brentwood, Maryland <sup>4</sup> □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral home, Inc. 6 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition years Glioblastoma **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760. ician/Medicai as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) the detached Physi 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. pe 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 2 2 No 1 Yes 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 1 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After ding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No М dea h. 2 Accident 24 hours after death Funeral Director 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ٥ D0061382 rama 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shama Ravi Mittal, M.D., 14816 Physicians Lane, Suite 152, Rockville, Maryland 20850 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 For

17309

29d. Date signed (Month, Day, Year)

12.

2008

May

|                                      | Registrar   |  |  | Cer.   | tificate of I  | Jeam         |                          |  | Reg. No                     | 2000   | 1730  |
|--------------------------------------|---|--|--|--|--|--------------|--------------------------|--|-----------------------------|--|---|
|                                      | 1. Decedent's Name (First, Middle, La   | ast)   |  |  |  |              |                          | 2. Date of Dea   | ath                         |  | 3. Time of Death  |
| an                                   | Percy   | Hugh   |  | Poc  | re   |              |                          | May 12   | 2, 2                        | Year<br>2008   | 2:00 A.M  |
| er<br>er                             | 4a. Facility Name (If not institution, gr   | ive street and number)   |  |  | 4b. City, Town, or   | Location     | of Death                 |  |                             | . County of Death  |   |
| Ci                                   | 3002 Merva Cou  |  |  |  | Fort W   | oobir        | aton                     |  |                             | Prince G   | aamaa la  |
|                                      |   |  | (In yrs. last birt   | hday)  | Fort W   | If Under     | 24 Hrs.                  | 8. Date of Birt  | h                           | 9 Birthi   | place (State or Foreign   |
|                                      | 418 07 9646   | 1 X M 2 □ F  | 39   | rs.  | Months Days  | Hours        | Min.                     | (Month, Da<br>11–2–19  | 18                          | Brial  | hton, AL  |
|                                      | Usual Residence of Decedent   |  |  |  |  |              |                          |  |                             | 102.19.  | 1100117 1115  |
|                                      | 10a. State 10b. County  |  | 10c. City, Town  | or Loc   | ation  |              |                          |  |                             |  | 10d. Inside City Limits   |
| ģ                                    | MD Prince G   | eorge's  | Ft. Was  | hin  | gton   |              |                          |  |                             |  | 1X Yes 2 □ No   |
| Funeral Director                     | 10e. Street and Number  |  |  |  | 10f. Zip Code  |              |                          |  | 10g. Ci                     | itizen of What Cou   | ntry?   |
| בַ                                   | 3002 Merva Ct.  |  |  |  | 20744  |              |                          |  | US                          | A  |   |
|                                      | 11. Marital Status  | 12. Was Decedent 8   | ver in U.S.  | 13. W  | │<br>Vas Decedent of H   | ispanic Or   | iain? (Sne               | cify Yes or No   | . 1                         | 14. Race - Ameri   | can Indian.   |
| 3                                    | 1 ☐ Never Married 2 ☐ Married   | Armed Forces?  |  | If   | Yes, specify Cuba  | n, Mexica    | n, Puerto F              | Rican, etc.)   |                             | Black, White,  |   |
| S C                                  | 3 □ Wever Married 2 □ Married   | If Yes, Give<br>Year or Dates:   |  | 1  | □Yes 2∏No  | Specify:     |                          |  |                             | Specify: W   | hite  |
| 2                                    | 15. Decedent's E  |  | l 16a  | Deced  | ent's Usual Occup  | ation        |                          |  | 16b k                       | Kind of Business/In  | ndustry   |
| 120                                  | (Specify only highest gi  | rade completed)  |  | (Give k  | kind of work done of NOT use retired   | during mos   | st of workin             | g  | , 0.5.                      |  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,   |
| Completed                            | Elementary/Secondary (0-12)   | College (1-4or 5-  |  |  | Plumber  |              |                          | I  | Cor                         | nstructio  | on  |
|                                      | 17. Father's Name (First, Middle, Las   | zt)  | Tide   |  | 1 I GIIIOCI  |              |                          | (First, Middle,  |                             |  |   |
| Be                                   | Felix Poore   | ~~   |  |  |  |              |                          | kett Po  |                             | ,  |   |
| 2                                    | 4 <del>-</del>  |  |  |  |  |              |                          |  |                             |  |   |
|                                      | 19a. Informant's Name/Relationship  |  |  |  |  |              |                          |  |                             | or Town, State, Zij  | _   |
|                                      | Julia A. Hilgenb  | erg  |  |  | dcliffe  |              |                          |  |                             |  |   |
|                                      | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐   | 7 Danis avec   france   Oberta   | 20b. Place of<br>cemeter   | Dispos<br>y, crem  | sition (Name of<br>atory or other plac   | e)           |                          | ate  | 20c. L                      | ocation - City or To   | own, State  |
| ļ                                    | 4 Donation 5 Other (Spec  |  |  |  | emorial  |              | 5–16-                    | -08  | Riv                         | erton, W   | V   |
|                                      | 23a. Part1. Enter the disease, or cor<br>shock, or heart failure. List only   | mplications that caused<br>y one cause on each lin   | e.   | ot ente  |  | ıg, such as  | s cardiac o              | r respiratory a  | rrest,                      |  | Approximate Interval Between Onset and Death  |
|                                      | Immediate Cause (Final disease or condition resulting in death)   | a. Cluro   | Consequence of   | 0 60<br>on:  | structi i<br>Ubuse   | re l         | ung                      | dis  | ea                          | re   |   |
|                                      |   | to   | ممع مما  |  | lauce  |              | 1.51                     |  |                             |  |   |
| 3-1                                  | Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying  |  | a consequence of   |  | W = 2 -  |              |                          |  |                             |  |   |
| Φ.                                   |   |  |  |  |  |              |                          |  |                             | I .  |   |
| mine                                 | Cause (Disease or injury  |  |  |  |  |              |                          |  |                             |  |   |
| Examine                              | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | c<br>Due to (or as a   | a consequence o  | of):   | ,  |              |                          |  |                             |  |   |
|                                      | Cause (Disease or injury that initiated events  | c<br>Due to (or as a   | a consequence o  | of):   | ,  |              |                          |  |                             |  |   |
|                                      | Cause (Disease or injury that initiated events  | c  | a consequence o  | of):   |  |              |                          |  |                             |  |   |
| /Medical Examiner                    | Cause (Disease or injury that initiated events resulting in death) Last   | d  | <u> </u>   | of):   |  |              |                          |  |                             | 20d Date of della  |   |
| n/Medical                            | Cause (Disease or injury that initiated events resulting in death) Last   | d  | of pregnancy<br>2 □ Fetal death  | 3 🗆  | Ectopic pregnanc   | y            |                          |  |                             | 23d. Date of deliv   | very<br>Day Year  |
| n/Medical                            | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No  | d23c. If yes, outcome of   | of pregnancy<br>2 □ Fetal death  | 3 🗆  | Ectopic pregnanc<br>Other (specify)  | y            | _                        |  |                             |  | ,   |
| n/Medical                            | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  | d  | of pregnancy<br>2 □ Fetal death<br>time of death                                       | 3 □<br>5 □   | Other (specify) _  |              |                          | 23c Did +  | phases                      | Month  | Day Year  |
| by Physician/Medical                 | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 23c. If yes, outcome of the birth of the bir | of pregnancy<br>2  ☐ Fetal death<br>time of death                                      | 3 🗆<br>5 🗆   | Other (specify)  | en in Part I |                          | -  |                             | Month use contribute to t  | Day Year the cause of death?  |
| by Physician/Medical                 | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  | 23c. If yes, outcome of the birth of the bir | of pregnancy<br>2  ☐ Fetal death<br>time of death                                      | 3 🗆<br>5 🗆   | Other (specify)  | en in Part I | I.                       | 23e. Did t   |                             | Month use contribute to t  | Day Year  |
| by Physician/Medical                 | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 23c. If yes, outcome of the birth of the bir | of pregnancy<br>2  ☐ Fetal death<br>time of death                                      | 3 🗆<br>5 🗆   | Other (specify)  | en in Part I | I                        | 24a. Was<br>autor<br>perfo   | res 2<br>an<br>osy<br>rmed? | Month  use contribute to to the contribute to th | Day Year the cause of death? bably 4 □ Unknown opsy findings available ompletion of cause of  |
| completed by rillysicial medical     | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant conditions   | 23c. If yes, outcome of the birth of the bir | of pregnancy<br>2  ☐ Fetal death<br>time of death                                      | 3 🗆<br>5 🗆   | Other (specify)  | en in Part I |                          | 24a. Was<br>autor<br>perfo<br>1 □ Yes                              | rmed?                       | Month  use contribute to to the contribute to th | Day Year the cause of death? bably 4 □ Unknown opsy findings available ompletion of cause of  |
| Be Completed by Physician/Medical    | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 23c. If yes, outcome of the birth of the bir | of pregnancy<br>2  Fetal death<br>time of death<br>it not resulting in                 | 3□<br>5□<br>the und  | Other (specify)  | 26. Place    | e of Death               | 24a. Was autop perfo   | rmed?                       | Month  use contribute to to to to to to to to to to to to to   | the cause of death?  bably 4 □ Unknown  opsy findings available ompletion of cause of  2 ☑ No |
| To Be Completed by Physician/Medical | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions  Light Lum  25. Was case referred to medical examiner? 1 □ Yes 2 ☑ No | 23c. If yes, outcome of the birth of the bir | of pregnancy 2   | 3□<br>5□<br>the und  | Other (specify)  | en in Part I | e of Death<br>ursing Hon | 1 ☑ \ 24a. Was autor perfor 1 □ Yes  (Check only one 5 ☑ 'Residue) | an<br>osy<br>rmed?<br>2 MN  | Month  use contribute to to to to to to to to to to to to to   | the cause of death?  bably 4 □ Unknown  opsy findings available ompletion of cause of  2 ☑ No |
| o Be Completed by Physician/Medical  | Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   | 23c. If yes, outcome of the pregnant at the pr | of pregnancy 2 Fetal death time of death it not resulting in 2 SER/Out y, Year) 28b. T | 3   5   the unit the unit that | derlying cause give to the control of the control o | en in Part I | e of Death<br>ursing Hon | 24a. Was autop perfo   | an<br>osy<br>rmed?<br>2 MN  | Month  use contribute to to to to to to to to to to to to to   | the cause of death?  bably 4 □ Unknown  opsy findings available ompletion of cause of  2 ☑ No |

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar 29b. Signature and title of certifier

Mesfin Gebremichael
31. Date filed (Month, Day, Year)

Gloremicheel

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D. 9801

DHMH 17 Rev 1/2001

29c. License number

D42354

Greenbelt Road, Suite 101, Lanham, MD 20706

|             |  |                  | 1 - For<br>State<br>Registrar  | Glate of 7                            | viarytario                   | Cei                  | rtificate of                           | Death              | workar rry                        | Reg. No.          | 08                         | 1/310   |
|-------------|--|------------------|--|---------------------------------------|------------------------------|----------------------|--|--------------------|-----------------------------------|-------------------|----------------------------|---|
|             | Physici  | an               | 1. Decedent's Name (First, Mid   |                                       |                              |                      |  |                    | 2. Date of De<br>Month            | eath<br>Day       | Year                       | 3. Time of Death                                      |
|             | /Medi  |                  | Suzanne Prin   |                                       |                              |                      |  |                    | May 1                             |                   |                            | 10:30 A <sup>N</sup>                                  |
| (6)         | Examir   | er               | 4a. Facility Name (If not instituti<br>221 Accident  |                                       |                              |                      | Acciden                                | or Location of Dea | th                                |                   | ty of Death<br>arrett      | =   |
| 43          | Funeral  |                  | 5. Social Security Number  | 12/21                                 | Age (In yrs. las             | t birthday)          | If Under 1 Year                        | If Under 24 Hrs    |                                   | rth Vanal         | 9. Birthp                  | place (State or Foreign<br>htry)                      |
|             | Director   |                  | 099-32-7844  | 1□ M 2 <b>∑</b> F                     | 73                           | Yrs.                 | Months Days                            | Hours Min          | Mar 23                            | 1935              |                            | OCCO  |
|             | and *  |                  | Usual Residence of Decedent<br>10a, State 10b, Coun  | tv                                    | 10c. City, 1                 | Town or Lo           | cation                                 |                    |                                   |                   | 1                          | IOd, Inside City Limits                               |
|             | Maryli<br>febo   | ō                | MD Garre   | •                                     | Accio                        |                      |  |                    |                                   |                   |                            | 1 ☐ Yes 2 🛣 No  |
|             | 128e-  | rect             | 10e. Street and Number   |                                       |                              |                      | 10f. Zip Code                          |                    |                                   | 10g. Citizen of   | What Cour                  | ntry?   |
|             | th with  | a D              | 221 Accident   | Garage Road                           |                              |                      | 215                                    | 520                |                                   | USA               | A                          |   |
|             | r dea  | Funeral Director | 11. Marital Status   | 12. Was Decede<br>Armed Force         | nt Ever in U.S.<br>s?        | 13.                  | Was Decedent of H                      | lispanic Origin? ( | Specify Yes or North Rican, etc.) | o- 14. Ra<br>Bla  | ce - Americ<br>ack, White, |   |
| 36          | ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Itam 27 ie marked other then "natural", or Iteme 23a or 28e-f show or other treumatic event, the Marylea Exami | by Fi            | 1 ☐ Never Married 2 ☑ Ma<br>3 ☐ Widowed 4 ☐ Divorce  | If Yes Give                           | s.                           |                      | 1 ☐ Yes 2 🛣 No                         | Specify:           |                                   | Spec              | ify:                       | white   |
| 9           | 2 hou  |                  | 15. Decede   | ent's Education                       |                              | 16a. Dece            | dent's Usual Occup                     | pation             |                                   | 16b. Kind of I    | Business/In                | dustry  |
| 21215-0036  | ithin 7  | Completed        | Elementary/Secondary (0-12)  | nest grade completed) ) College (1-4c | or 5+)                       | life.                | kind of work done<br>DO NOT use retire | d) most of wo      | orking                            |                   |                            |   |
| 2           | Hygien<br>Hygien<br>Stherth  |                  | 47 Fabrus Norma (Fire Addut  | 4 yrs.                                |                              | Compa                | enion                                  | 10 Mathada Ma      | ome (Class Stindelle              | Domes             |                            |   |
| Maryland    | ntal Hed of  | Be               | 17. Father's Name (First, Middle   | e, Last)                              |                              | Benda (              | mion                                   | Alice              | ame (First, Middle                | a, Maiden Suma    | ine)                       |   |
| 2           | should<br>nd Men<br>marke  | 2                | 19a. Informant's Name/Relation   | nship (Type, Print)                   |                              |                      | g Address (Street                      |                    |                                   | per, City or Town | n, State, Zip              | Code)   |
|             | t and 2 s<br>Health ar<br>am 27 le   |                  | Paul K. Prin   | e/husband                             |                              | 221 2                | Accident                               | Garage F           | Rd., Acc                          | ident, N          | MD 2                       | 1520  |
| ore,        | of He<br>of He<br>fitam<br>roth  |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation  |                                       | com                          | e of Disponence      | sition (Name of matory or other pla    |                    | Date                              | 20c. Location     |                            |   |
| altimore,   | Z = E D  |                  | 4 Donation 5 Other   |                                       | MSVC                         |                      | cky Gap                                |                    | L3, 2008                          | Flint             | stone                      | , MD.   |
| Bail        | permit. Page<br>Department o<br>Important: If<br>eny Injury or<br>once.  |                  | 21. Signature of Funeral Service   | M a                                   |                              |                      | 2. Name and Addre                      |                    | nes, P.A                          | . P.O.            | Box 2                      | 275   |
|             | 4  |                  | 23a. Part1. Enter the disease, shock, or heart failure. Li   | or complications that cause           | sed the death                | Do not ent           | 79 Miller                              | St. CaG            | antsvil                           | le, MD            |                            | 5<br>Approximate                                      |
|             | Discolation  |                  | shock, or heart failure. Li<br>Immediate Cause (Pinal  | ist dnly one cause on each            | line.                        |                      |  | 1                  | 200                               |                   |                            | Interval Between<br>Onset and Death                   |
| è           | Physician /Medical   |                  | disease or condition resulting in death)   | a. Due to (or                         | as a conseque                | nce of):             | iance                                  | nord               | Can                               | cer               |                            |   |
| *           | Examiner   | ļi.              | Comment of the state of the sta | CITE                                  | 20                           | Sen                  | es Mi                                  | (tra)              | Sten                              | Dis               |                            |   |
|             | D #  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or                            | as a consequer               | nce of):             | ,                                      | 1                  | ,                                 |                   | ,                          |   |
|             | ecute<br>and<br>trans  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last  | a Let                                 | as a conseque                | nd                   | icula                                  | dy                 | stun                              | etro              | 2                          |   |
| 60,         | be ex<br>iicien<br>burial  |                  | ,,,  | Due to (or                            | as a conseque                | 1100 01).            |  | 0                  | 0                                 |                   |                            |   |
| 68760,      | rificate be executed<br>ng physicien and<br>as the burial-transit  | Medical          |  | d                                     |                              |                      |  |                    |                                   |                   |                            |   |
| Box         |  |                  | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcor                   | me of pregnanc               |                      | Ectopic pregnanc                       |                    |                                   |                   | ate of deliv               |   |
| о<br>С      | law requires that the death ce<br>as been signed by the atlendi<br>2 should be detached for use  | Physician/I      | in the past 12 months?   |                                       | at time of deat              |                      | Other (specify)                        | у                  |                                   | N                 | fonth                      | Day Year  |
| 0.          | hat the<br>d by t<br>letach  | Phy              | 9 Unknown Part U Other significant condi   |                                       |                              | ng in the u          | ndorh/ing cauco au                     | uon in Part I      | 23a Did                           | tobacco use co    | ntribute to t              | he cause of death?                                    |
| ds,         | signe<br>d be c  | d by             | Breast C   | Pane                                  |                              | ing an ane u         | nderlying cause gr                     | ven in Fatti.      |                                   | Yes 2 No          |                            | bably 4 Unknow  |
| Records,    | * requ<br>been<br>shoul  | Completed        | CASSIT   | A A                                   | F G                          | 0                    | 0 )                                    |                    | 24a. Wa                           |                   | Were auto                  | onsy findings available                               |
| æ           | Physicien: The lavithis certificete has  | m<br>d           | Congestin  | 1.00                                  | 0 / 6                        | ue                   |  |                    | auto                              | ormed ?           | death?                     | opsy findings available ompletion of cause of<br>2 No |
| Vital       | Attending Physicien: The roleath. sctor: After this certificete his y the funeral director, page   | 0                | 25. Was case referred to media   | cal                                   |                              |                      |  | 26. Place of De    | eath (Check only                  | one)              | 1 🗆 Yes                    | 2U NO   |
| <u></u>     | hysica<br>his ce<br>I direc  | To B             | examiner?  | Hospitat: 1 ☐ Inp                     | atient 2□EF                  | VOutpatier           | nt 3□ DOA Ott                          | ner: 4 🗌 Nursing   | Home 5 Res                        | idence 6 🗆 O      | ther (Specia               | (y)   |
| u o         | ding Pl<br>h.<br>After ti<br>funera  |                  | 27. Magner of Death<br>1 X Natural 5 ☐ Pend  | 28a. Date of I<br>(Month,             | njury<br>Day Year)           | 8b. Time o<br>Injury | Wo                                     |                    | 28d. Describe                     | how injury occu   | urred                      |   |
| Sio         | ttend<br>death<br>stor: /  | cat              | 3 Suicide 6 □ Coul   |                                       | Injuny - At hom              | o farm et            | M 1 =                                  | Yes 2□No           | 28f Location                      | (Street and Nun   | nher or Run                | al Route Number,                                      |
| Division of | after<br>Direct  | Certification:   | 4 Homicide dete  | building,                             | etc. (Specify)               | e, iaiii, su         | eet, ractory, onice                    |                    | City or To                        | wn, State)        | NOO! OF FIBE               | ar modite i volinoer,                                 |
|             | ospite<br>hours<br>unerel<br>y fillec  | alC              | 29a. Certifier 157 Certify   | ying Physician: To the be             | st of my knowle              | edge, deat           | h occurred at the tr                   | me, date and place | e, and due to the                 | cause(s) and r    | manner as s                | stated.   |
|             | To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the   | ledical          | one)   | al Examiner: On the basis             | s of examination stated.     | n and/or in          |  |                    | curred at the time                |                   |                            |   |
|             | To T<br>To T   | Σ                | 29b. Signature and title of certif   | fier                                  | D.                           | ^                    | 29c. Licens                            | se number          |                                   | 29d. Date sign    |                            |   |
| ,           |  |                  | Koh  | (mx                                   | M.                           | 77                   | D                                      | 2034               | 231                               | May 12            | 2, 200                     | )8  |
|             |  | 6                | 30. Name and address of person   |                                       |                              |                      | _                                      | 1. 1               | 33                                |                   |                            |   |
|             | y <sup>ad</sup> Sta  | te               | 124 Miller St<br>31. Date filed (Month, Day, Yea   | ar) 32. Pleg                          | LIE, MD<br>istrar's Signatur |                      | 0.50 RC                                | bin Biss           | sell, M.I                         | ).                |                            |   |
| 2           | Regist   | _ "              | MAY 1  | 4 2008                                | gues l                       | Y A                  | 230/20                                 |                    |                                   |                   |                            |   |

| Physician /Medical Examiner  4a. Facility Name (If not institution, give street and number) Potomac Valley Nursing Center  Funeral Director  Funeral Director  Pusual Residence of Decedent 10a. State 10b. County MD Montgomery  10c. City, Town or Location Wheaton  10f. Zip Code 20902   | 2. Date of Death Month Day Year May 8, 2008 10:00 P  4c. County of Death Montgomery  3. Date of Birth (Month, Day, Year) MD  9. Birthplace (State or Fore Country) MD  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: Black              | M   |
|--|--|-----|
| Light   Compared   C   | May  8, 2008 10:00 P  4c. County of Death  Montgomery  3. Date of Birth (Month, Day, Year)  May 23, 1943  9. Birthplace (State or Fore Country)  MD  10d. Inside City Lim  1 □ Yes 2 ☑ 1  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify: | M   |
| Potomac Valley Nursing Center  Funeral Director  Potomac Valley Nursing Center  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 4 Yrs.  Rockville  7. Age (In yrs. last birthday) 4 Yrs.  Months Days Hours Min.  1 M 1 M 2 F 8 Min.   | Montgomery  3. Date of Birth (Month, Day, Year)  May 23, 1943  9. Birthplace (State or Fore Country)  MD  10d. Inside City Lim  1 □ Yes 2 ☑ 1  10g. Citizen of What Country?  USA  Ify Yes or Nocican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:                 |     |
| Funeral Director  5. Social Security Number 6. Sex 1 Months Days Hours Min. 1 Months Days Hours  | 3. Date of Birth (Month, Day, Year) May 23, 1943  9. Birthplace (State or Fore Country) MD  10d. Inside City Lim 1 □ Yes 2 ☑1  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify:  |     |
| Director 213-42-9109 12 F 64 Yrs. World's Day's Tools Will.  | May 23, 1943 MD  10d. Inside City Lim 1 □ Yes 2 ☑ I  10g. Citizen of What Country?  USA  Ify Yes or No- ican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:  | ign |
| Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location Wheaton  10c. Street and Number 10c. Street and Number 10c. Zip Code 2205 Shorefield Road 20902  | 1 ☐ Yes 2 ☑ I  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify:  |     |
| with the Mary term of the Political Properties of the Will Hamilton of the Political Properties of the Will Hamilton of the Political Properties of the William Properties of  | 1 ☐ Yes 2 ☑ I  10g. Citizen of What Country?  USA  14. Race - American Indian, Black, White, etc.  Specify:  | its |
| the state of the s | ify Yes or No- ican, etc.)  14. Race - American Indian, Black, White, etc.  Specify:   |     |
| The second secon | ify Yes or No-<br>ican, etc.)  14. Race - American Indian,<br>Black, White, etc.  Specify:   |     |
| 8 42 5   | Specify:   |     |
| 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specific Policy Cuban, Mexican, Puerto Ri   | Specify: Black   |     |
| o g = 5  |  |     |
| To be the state of the state o  | 16b. Kind of Business/Industry   |     |
| 15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Carpenter  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Carpenter  |  |     |
| Carpenter 9  | Construction   |     |
| フェディラン 17. Father's Name ( <i>First, Middle, Last</i> ) 18. Mother's Name ( <i>i</i> 中国 タン ロ Theodore Parker   | First, Middle, Maiden Surname)   |     |
| Theodore Parker  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural in the control of the con | Ellen Johnson  | —   |
| The state of the s | ,  |     |
| 20a. Method of Disposition  20b. Place of Disposition (Name of cernetery, crematory or other place)  | ,  |     |
| 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  | 008   Port Republic, MD  |     |
| 21. Signature of Funeral Service Licensee  22. Name and Address of Facility  |  |     |
| Sewell tilleral Home, 1.A., 1431   | Dares Beach Rd., Prince Frederick, MD 206 respiratory arrest. Approximate  | 378 |
| 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final   | Interval Between<br>Onset and Death  |     |
| Physician Immediate Cause (Final disease or condition resulting in death)  /Medical / Medical Due to (or as a consequence of):   | cer 6 month  | 5   |
| Examiner   |  |     |
| b Sequentially is conditions, if any, leading to immediate Due to (or as a consequence of):  |  |     |
| farry, leading to immediate cause. Enter funderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |  |     |
| the burial  |  |     |
| Cause (Disease or injury that initiated events resulting in death) Last    Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events resulting in death) Last   Cause (Disease or injury that initiated events  |  |     |
| The second property of the position of the p   | 23d. Date of delivery  |     |
| in the past 12 months?    Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Security   Image: Second Second Security   Image: Second Security   Image: Second Second Second Security   Image: Second  | Month Day Year   |     |
| 1 to the significant conditions contributing to death but not resulting in the underlying cause given in Part I.   | 23e. Did tobacco use contribute to the cause of death?   |     |
| Faction of the significant conditions continuously to death out not resulting in the underlying cause given in Part i.   | 1 ☐ Yes 2 ☐ No 3 ♣ Probably 4 ☐ Unkno  |     |
| The law requires to page 2 should be completed by  | 24a. Was an 24b, Were autopsy findings availa  |     |
| n d d d d d d d d d d d d d d d d d d d  | autopsy prior to completion of cause of death?   |     |
| 25. Was case referred to medical examiner?   | 1   Yes 2   No   1   Yes 2   No     No   |     |
| examiner?    Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home   | e 5 ☐ Residence 6 ☐ Other (Specify)  |     |
| 28a. Date of Injury 28b. Time of 128 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?  | 3d. Describe how injury occurred   |     |
| 27. Manner of Death 1. SNatural 5   Pending investigation 3   Suicide 4   Homicide 1. Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 1   Yes 2   No 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office   | Other Country (Charles and March and Electrical Country)   |     |
| determined determined building, etc. (Specify)   | <ol> <li>Location (Street and Number or Rural Route Number,<br/>City or Town, State)</li> </ol>  |     |
| The second of th | nd due to the cause(s) and manner as stated.   | _   |
| FEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Yes 2   No 9   Unknown   20      | d at the time, date and place, and due to the cause(s)   |     |
| 29b. Signature and title of certifier 29c. License number  | 29d. Date signed (Month, Day, Year)  |     |
| The College of My 0 30262  | 11/ax 4, 2000  |     |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)  A MENDHIRATTA 2401 Research 13 Ivd. Suite  | : 330 Rockville, MD  |     |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | - '  |     |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:20 9, 2008 May Ronald Α. Parise /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 15419 Good Hope Road Silver Spring Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F **Funeral** 56 Months Days Hours Min. 298-46-7272 Director May 24, 1951 Ohio Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f sho 1 ∐ Yes 2xt TNo Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 20905 USA 15419 Good Hope Road Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: 5 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Industry Astrophysicist ulth and Mental Hygiv 27 is marked other r traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B Pages 1 and 2 should be Cathryn Anna Pasha Henry John Parise ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) nt of Health a E. If Item 27 is for other tra 15419 Good Hope Road, Silver Spring, MD 20905 Cecelia M. Parise/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Burtonsville Union 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 17, permit. Page Department of Important: If any injury or 4 □ Doration 5 □ Other (Specify) 2008 Burtonsville, Maryland Cemetery Funetal ervice LV risee Signature 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. annos 500 University Blvd. W. Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Years Glioblastoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine lor Attending Physician: The law requires that the death certificate be executed after death. g physician and strang Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) P.O. certificate has been signed by the rector, page 2 should be detached 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by Seizure Disorder 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 □ Yes 2 X No 1 ☐Yes 2 ☐No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 ∐Yes 2 k No Certification: To After this 28c. Injury at Work? 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natura 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier rifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Priffying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the value (s) and maintenance and due to the value (s).

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the pages stated. Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D45956 May 9, 2008 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dawn Broderick, MD 18109 Prince Philip Drive, #275, Olney, MD 20832 31. Date filed (Month, Man Year 3 32. Reastrar's Signature State 2008 CO HOLD Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] 8 For State Registrate FND#23a, Pt. I, perMD, 5/13/08, DPS, McCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Rosalie Mary Parcelli May 11, 2008 6:50 a /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 8. Date of Birth (Month, Day, Year) Aug. 27, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 1 F Yrs. Director 579-01-7326 92 1915 Ohio Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Directo Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5703 36th Avenue 20782 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 SpecifyWhite 1 ☐ Yes 2 🛣 No Specify þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth eny injury or other traumatic event 9088. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Joseph Fondale Anunciatta Sparzano 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carlo V. Parcelli/Son 5703 36th Avenue, Hyattsville, MD 20782 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State May 15, Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 — Silver Spring, Marylani 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Obses /Medical Examiner bailure ar bivalory if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Anemu the attending physician and hed for use as the burial-tra-Due to (or as a consequence of). P.O. Box 68760. Physician/Medical Hypoxia IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be 1 Yes 2 No 3 Probably 4 Munknown Completed 24b. Were autopsy findings available prior to completion of cause of death? ...
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? 1 Yes 2 No director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred s after de... rel Director: Afte 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \( \text{Homicide} \) To the Hospital within 24 hours a To the Funeral I completely filled Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) 06383 08 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Padma Chirumamilla, MD

1 3 2008

31. Date filed (Month, Day, Year)

7600 Carroll Avenue, Takoma Park, MD 20912

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician MON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Vantage House Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Hours Months Days 153cM 2□F Yrs Director 211 18 5175 June 21,1925 Washington DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road AL426 21044 United States by Funeral items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status "natural", or items edical Examiner n Black, White, etc. 1 ☐ Never Married 2 Married 1 X Yes 2 No If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Firefighter DC Fire Department 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Raymond C. Roberts, Sr. Pauline Mothershead 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph 1 and 2 more and 2 more and 2 in mportant: If item 27 is n any Injury or other training once. Peggy L. Roberts/Wife 5400 Vantage Point Rd AL426 Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Vet. Cem. 5-15-2008 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Collins 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) DEBILI Physician /Medical Due to (or as a consequence of): Examiner MENTI Sequentially list conditions, if any manifest cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ISEASE KINSUM'S physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deaths ģ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a. Was an perform 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3□ DOA 4 Nursing Home 5 Residence 6 Other (Specif 27. Manne of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 [ / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated

certificate be exec Box 68760, Division or Vital Records, P.O.

filed within 72 hours after death

3altimore, Maryland 21215-0036

al or Attending Patter death.
I Director: After de in by the funera After within 24 hours a

To the Funeral I Hospital

011

State Registrar

29b. Signature and title of certifie

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUIT

31. Date filed (Month, Day, 32. Registrar's Signature MAY 13 2008

|   | _              | For<br>State<br>Registrar  |  | Cer                            | tificate                 | of Death                                       |                                 | Reg. I                       | No.                           |   |  |
|---|----------------|--|--|--------------------------------|--------------------------|--|---------------------------------|------------------------------|-------------------------------|---|--|
| Physicia  | an             | Decedent's Name (First, Middle, Last)                                  |  |                                |                          |  | 2. Date of<br>Month             |                              | Day Year                      | 3. Time of Death                                  |  |
| /Medic  |                | Arthur Hayward Rea  4a. Facility Name (If not institution, give str    |  |                                | 4h City 1                | own, or Location of D                          | 05<br>Death                     | 0                            | 6 2008<br>4c. County of Dea   | 11:45 P <sup>M</sup>                              |  |
| Examin  | er             | Garrett County Mem   |  | <b>.</b> 1                     | 0ak]                     |  |                                 |                              | Garrett                       |   |  |
| Funeral   |                | 5. Social Security Number 6. Sex                                       | 7. Age (In yrs. I  |                                | If Under                 | 1 Year If Under 24                             | Hrs. 8. Date of                 | Birth                        | 9. Bir                        | thplace (State or Foreignantry)                   |  |
| Director  |                | 218-16-2975  | <sup>1 2□ F</sup> 83   | Yrs.                           | Months                   | Days Hours                                     | Min. (Month, 10/02              | Day, Yea<br>/192             |                               | yland   |  |
|   |                | Usual Residence of Decedent  | 100 00   | , Town or Lo                   |                          |  |                                 |                              |                               | 10d. Inside City Limi                             |  |
| hov m   | 7              | 10a. State 10b. County   |  |                                | cation                   |  |                                 |                              | 10a. Insid                    |   |  |
| - 8a-   | Director       | MD Garrett  10e. Street and Number                                     | Ua   | akland                         | 10f. Zip                 | Codo   |                                 | 100                          | Citizen of What C             | ountar?   |  |
| 0   | 급              |  | D 4  |                                |                          | 550  |                                 | 109.                         | USA                           | outiny :  |  |
| ne 23   | Funeral        | 2279 Swallow Falls  11. Marital Status 12                              | . Was Decedent Ever in U.S                                   | S. 13. V                       |                          | ent of Hispanic Origin<br>fy Cuban, Mexican, F | ? (Specify Yes or               | No-                          | 14. Race - Ami                |   |  |
| Hygiene.<br>ther than "natural", or iteme 23a or 28a-f show<br>ont, the Madical Examinar must be multified at | by Fun         | 1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced                 | Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:      |                                | fYes,spec<br>∣⊡Yes 2     |  | <sup>p</sup> uerto Rican, etc.) |                              | Black, Whi                    | te, etc.<br>White                                 |  |
| 1 m   | edk            | 15. Decedent's Educa   | tion   | 16a. Deced                     | lent's Usua              | l Occupation                                   |                                 | 16b                          | . Kind of Business            |   |  |
| o di  | Completed      | (Specify only highest grade of   | completed)   | (Give<br>life. L               | kind of wor<br>OO NOT us | k done during most o<br>e retired)             | f working                       |                              |                               | ,   |  |
| e de la   | E O            | Elementary/Secondary (0-12) 7 th                                       | College (1-4or 5+)   | Car                            | pente                    | r  |                                 |                              | Constru                       | cton  |  |
| ital Hygiene. id other then "naturevent, the Mayles   | Bec            | 17. Father's Name (First, Middle, Last)                                |  |                                |                          | 18. Mother's                                   | Name (First, Mid                | dle, Maio                    | den Surname)                  |   |  |
| to Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the Me                | 2              | Bliss Oliver Reams   | 3  |                                |                          | Gra  | ce Olivi                        | a Cro                        | oss                           |   |  |
| and<br>ie m   | 17             | 19a. Informant's Name/Relationship (Type                               | , Print)   |                                |                          | (Street and Number                             |                                 |                              |                               |   |  |
| Health<br>tem 27<br>other tra   |                | Evelyn E. Reams /  | Wife   |                                |                          | ow Falls                                       | Road, Oa                        |                              |                               |   |  |
| nent of H<br>int: If ite<br>iry or otl  |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer            | noval from State   | lace of Dispo<br>emetery, cren |                          |  |                                 |                              | . Location - City or          |   |  |
| tant:   |                | 4 □ Donation 5 □ Other (Specify)                                       | Tay  |                                |                          | Cemetery 5                                     |                                 | _                            | kland, M                      |   |  |
| Department of important: If eny injury or once.   |                | 21. Signature of Funeral Service Licenses                              | 116  |                                |                          | Address of Facility                            |                                 |                              |                               |   |  |
| . L z v u   |                | 23a, Part1. Enter the disease, or complica                             | tions that assess the death                                  |                                |                          |  |                                 |                              | and, Mar                      | yland 2155  |  |
|   |                | shock, or heart failure. List only one                                 | cause on each line.  | i. Do not ente                 | or the mode              | o or dying, such as ca                         | irdiae or respirator            | y arrost,                    |                               | Interval Between<br>Onset and Death               |  |
| hysician<br>/Medical  |                | disease or condition resulting in death)                               | Pneumonia  |                                |                          |  |                                 |                              |                               | 1 week  |  |
| xaminer   |                |  | Due to (or as a consequ<br>COPD                              | uence of):                     |                          |  |                                 |                              |                               | Years   |  |
|   | e              | Sequentially list conditions, if any leading to immediate              | Due to (or as a consequ                                      | uence of                       |                          |  |                                 |                              |                               |   |  |
| dansit  | Examin         | cause. Enter Underlying Cause (Disease or injury that initiated events |  |                                |                          |  |                                 |                              |                               |   |  |
| an an<br>ial-tr   | Exa            | resulting in death) Last   | Due to (or as a consequ                                      | uence of):                     |                          |  |                                 |                              |                               |   |  |
| physicien and is the burial-transit   | edical         | d.   |  |                                |                          |  |                                 |                              |                               |   |  |
|   |                | IC COMME   |  |                                |                          |  |                                 |                              |                               |   |  |
| e attending<br>ed for use as  | Physician/M    | 23b. was decedent pregnant   | t. If yes, outcome of pregnate 1 ☐ Live birth 2 ☐ Fetal      |                                | Ectopic pre              | egnancy  |                                 |                              | 23d. Date of de<br>Month      | elivery<br>Day Year                               |  |
| 0 0   | sici           | in the past 12 months? 1 ☐ Yes 2 ☐ No                                  | 4 Pregnant at time of de<br>9 Unknown                        | eath 5□                        | Other (spe               | ecity)   |                                 | -                            | MOILLI                        | Day 16a1  |  |
| signed by the s   | P.             | 9 ☐ Unknown  Part II. Other significant conditions contr               | ibuting to dooth but not soon                                | ulting in the                  | a da ah iina a           | use suce in Bost I                             | 230 [                           | hid tobacc                   | no use contribute t           | to the cause of death?                            |  |
| ste has been signed by those age 2 should be detached   | þ              | Valvular heart dis   | •  | •                              |                          | •  |                                 |                              |                               | robably 4 Donknov                                 |  |
| been si<br>should b   | ed             | valvular heart dis   | sease w/aulti  | L Valv                         | e rep                    | Tacement                                       |                                 | -                            |                               |   |  |
| has t   | Completed      |  |  |                                |                          |  | a                               | Vas an<br>utopsy<br>erformed | prior to                      | utopsy findings availat<br>completion of cause of |  |
|   |                |  |  | <del></del>                    |                          |  | 1 □ Ye                          |                              |                               | s 2 No  |  |
| r this certificete<br>ral director, pag   | Be             | 25. Was case referred to medical examiner?                             | spital:  |                                |                          | Othor  | f Death (Check or               |                              |                               |   |  |
| rthis<br>analdi   | . To           | 1 Yes 2 No   | 28a. Date of Injury  | 28b. Time of                   |                          | A  |                                 |                              | e 6 □Other (Speniury occurred | эсігу)  |  |
| Afte<br>fune  | i              | 1 Natural 5 Pending 2 Accident investigation                           | (Month, Day Year)  | Injury                         | м                        | Work?<br>1 ☐ Yes 2 ☐ No                        |                                 |                              | . ,                           |   |  |
| octor<br>by the   | Certification: | 3 Suicide 6 Could not be determined                                    | 28e. Place of Injury - At ho<br>building, etc. (Specify      | ome, farm, str                 | eet, factory             | , office                                       | 28f. Location<br>City or        | n (Street<br>Town, S         | t and Number or F<br>tate)    | Rural Route Number,                               |  |
| # 5 =   | edical Ce      | (Check only 2 Medical Examine  | einn: To the baut of my know<br>or: On the basis of examinat |                                |                          |  |                                 |                              |                               |   |  |
| 4 hours aft<br>Funerel Di   |                | 29b. Signature and title of certifier                                  | and manner stated.   |                                | 290                      | License number                                 |                                 | 294                          | Date signed (Mor              | ith, Day, Year)                                   |  |
| hin 24 hours aft<br>the Funerel DI<br>mpletely filled in  | Med            |  | 1/   |                                | 230                      |  | 2-                              | 230.                         | Sate signed (Mar.             | , 20, , 00//                                      |  |
| within 24 hours after death.  To the Funerel Director: After the completely filled in by the funeral          | Med            | 250. Signature and title or continuer                                  | <i>Y</i>   |                                |                          | 1)/  | 47                              |                              | 5/1/0                         | 7   |  |
| within 24 hours aft<br>To the Funerel DI<br>completely filled in  | Med            | +1/0   | hum  | 00.10                          |                          | D123   | 553                             |                              | 5/3/0                         | 2   |  |
| within 24 hours aft.  To the Funerel Di  completely filled in   | Med 10         | 30. Name and address of person who can Thomas G. Johnson M.            |  |                                |                          | akland M                                       | arvland                         | 1550                         | 5/2/0                         | 2   |  |

Casey Stephanie Smallwood

08-03379

UNK UNK

State of Maryland

| pe or Print in Black Indelible ink. Ensure All Copies Are Legible. |      |      |
|--|------|------|
| tate of Maryland / Department of Health and Mental Hygiene         | 2008 | 1731 |
| Confidence of Doodh  |      |      |

| UNK UNK  |                | S<br>1- For State   | tate of Marylar  |                                |                                    |                          | nd Ment         | al Hygier                        | ne<br>ne                   | 20                          | 08 173   | 3        |  |
|--|----------------|---|--|--------------------------------|------------------------------------|--------------------------|-----------------|----------------------------------|----------------------------|-----------------------------|--|----------|--|
| 8,   |                | Registrar<br>1. Decedent's Name (First, Midd                      | tlo Last)  | Ce,                            | rtificate of                       | Death                    |                 | 2. Date                          | Reg.<br>e of Death         | No.                         | 3. Time of Death                               | $\neg$   |  |
| Physicia<br>Medical Examin   | 400            | Casey   | Stephan:   | io                             |                                    | Smallw                   | 500°            | Mon                              |                            | Pay Year                    | 0605 hrs                                       |          |  |
| The same of the sa |                | 4a. Facility Name (if not instituti                               | on, give street and num  | nber)                          |                                    | 4b. City, Town,          |                 |                                  |                            | 4c. County of De            |  |          |  |
| `  |                | 5006 G Buchannon S  | Street   |                                |                                    | Edmonste                 |                 |                                  | 15                         | Prince Geor                 | •  |          |  |
| Funeral  |                | 5. Social Security Number   |  | 7. Age (In yrs.                | last birthday)                     | If Under 1 Y<br>Months D |                 | Min                              |                            | For                         | Birthplace (State or reigrWashingt<br>Country) | eo h     |  |
| Director   |                | 212-31-2632   | 1 M 2XF  | 19                             | Yrs                                |                          | , ,             | 0,                               | 7/16/                      | /1988                       | Country) DC                                    | _        |  |
| any  |                | Usual Residence of Decedent<br>10a. State 10b. County             | ,  | 10c. City                      | , Town or Locat                    | ion                      |                 |                                  |                            |                             | 10d. Inside City Limi                          | its      |  |
| <u> </u>   | L              | Maryland C  | harles   |                                |                                    | Ţ                        | Valdoi          | ~f                               |                            |                             | 1 X Yes 2 N                                    | No       |  |
| larylar<br>.8a-f s   | Director       | 10e. Street and Number  | . Idl 105  |                                |                                    | 10f. Zip Code            |                 |                                  | 10g                        | Citizen of What Country?    |  |          |  |
| the M  | Pig            | 11707 Troy Court 20   |  |                                |                                    |                          |                 |                                  | 601 USA                    |                             |  |          |  |
| sath with the Maryland<br>items 23a or 28a-f show<br>ust be notified at once.  | ā              | 11. Marital Status  | 12. Was Dece   |                                |                                    |                          |                 | in? ( Specify Y<br>Puerto Rican, |                            | 14. Race - An<br>White, etc | nerican Indian, Black,                         |          |  |
| r deat<br>or ite   | Fun            |   | Married Armed For 1 Yes  | 2 X No                         |                                    | Yes 2X                   |                 |                                  |                            | Specify: F                  | Black  |          |  |
| irs afte<br>ural";<br>miner  | by             | 3 Widowed 4 D  15. Decedent's Education (Sp                       | or Dates:  |                                |                                    |                          |                 | kind of work do                  | ne 1                       | 16b. Kind of Busine         |  | -        |  |
| 72 hou   | Completed      | Elementary/Secondary (0-12  |  |                                | during m                           | ost of working           | life. DO NOT    | use retired)                     |                            |                             |  |          |  |
| 5-0036<br>fled within 7<br>Hygiene<br>1 other than   | mpl            | 12  |  |                                | (                                  | Cleane                   |                 |                                  |                            |                             | ect Inc.                                       |          |  |
| 15-0<br>filed w<br>Hygie<br>d othe   |                | 17. Father's Name (First, Middle                                  |  |                                | _                                  |                          |                 |                                  | Middle, Ma                 | aiden Surname)              |  |          |  |
| 2121<br>ould be fi<br>Mental I<br>marked   |                | Van<br>19a. Informant's Name/Relation                             | Sushin (Type, Print.)  |                                | Smally                             | √OOd<br>a Address (Si    | Tina            | ber or Rural R                   | oute Numb                  | er, City or Town, S         | Adams<br>tate, Zip Code)                       | -        |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygione. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once   | ۲              | Tina Smallwo  |  | er                             | 1.0                                |                          |                 |                                  |                            |                             | nd 20601                                       | - 1      |  |
| e, N<br>I and I<br>Health<br>item  | 1              | 20a. Method of Disposition  |  | 20b.                           | Place of Dispos<br>crematory or of | sition (Name of          |                 | Date                             |                            | 20c. Location - City        |  |          |  |
| Baltimore,<br>permit. Pages 1 a<br>Department of He<br>important: If it,   | -              | 1 X Burial 2 Crematic   |  | m State R                      | esurre                             |                          |                 | 5/15/                            | 08                         | Clinton                     | ,Maryland                                      |          |  |
| alti<br>mit. ]<br>partm<br>iporta<br>lury o  |                | 21. Signature of fluneral Service                                 |  |                                | 22.1                               | Name and Addi            | ess of Facility | Adams                            | Fur                        | neral Ho                    | ome PA   | $\neg$   |  |
| 100000000000000000000000000000000000000  |                | Hoyl E  |  | 19                             | 1 20                               | )605 A                   | quasc           | o Rd.                            | Aqua                       | sco, Mar                    | yland 206                                      |          |  |
| Physician<br>/Medical  |                | 23a. Part I. Inter the disease, of failure. List only one cause   | e on each line.  |                                |                                    |                          | ng, such as c   | ardiac or respir                 | alory arres                | st, SHOCK, OF Heart         | Between Onset ar                               |          |  |
| vaminer  |                | Immediate Cause (Final diseas<br>or condition resulting in death) | Due to (or as a  |                                |                                    | Chest                    |                 |                                  |                            |                             | - Death  | -1       |  |
|  |                | Sequentially list conditions,                                     | b  | 00.100420.100                  |                                    |                          |                 |                                  |                            |                             |  |          |  |
|  | iner           | if any, leading to immediate                                      | Due to (or as a  | consequence                    | of):                               |                          |                 |                                  |                            |                             |  |          |  |
| =  | Examiner       | (Disease or injury that initiated events resulting in death) Last | C  | consequence                    | of):                               |                          |                 |                                  |                            |                             |  | $\dashv$ |  |
| ),<br>be executed<br>sician and<br>urial - transit   |                |   | d  |                                |                                    |                          |                 |                                  |                            |                             |  |          |  |
| O,<br>: be ex<br>sician  | edical         | UNPENDED  | AMENDED  |                                |                                    |                          |                 |                                  |                            | Tarini viii                 |  | _        |  |
| cords, P.O. Box 68760 Iaw requires that the death certificate that been signed by the attending physion is should be detached for use as the but it is the but in the but in the but it is the but it is the but it is the but in the b | Physician/Me   | IF FEMALE:<br>23b. Was decedent pregnant in                       |  | outcome of pre<br>rth          |                                    | etal death               | 3 Ectopie       | c pregnancy                      |                            | 23d. Date of deli<br>Month  | Day Year                                       |          |  |
|  | sicia          | past 12 months?  1 Yes 2 No 9 V U                                 | alia a iiia  | ant at time of d               | eath                               | ther (Specify)           |                 |                                  |                            |                             |  | - 1      |  |
| . Box<br>the death of<br>y the atten   | Phys           | Part II. Other significant cond                                   | a orikilo  |                                | resulting in the                   | underlying cau           | se given in Pa  | art I 2                          | 3e. Did tob                | acco use contribut          | e to the cause of death?                       | $\dashv$ |  |
| P.O<br>ss that t   | þ              | Tart II. Other Significant Cond                                   | the state of the s | dealir but not                 | resulting in the                   | underlying cou           | 50 g. (61 m. )  |                                  |                            |                             | Probably 4 Unknow                              |          |  |
| ds,<br>equire<br>een sij   | Completed      |   |  |                                |                                    |                          |                 |                                  | 4a. Was ar                 |                             | e autopsy findings availa                      |          |  |
| of Vital Records, g Physician: The law require ther this certificate has been si neral director, page 2 should t   | mpl            |   |  |                                |                                    |                          |                 |                                  | autops<br>perforn<br>Yes 2 | ned? deat                   | to completion of cause of h? Yes 2 No          | - 1      |  |
| tal Rection: The I certificate lector, page  |                | 25. Was case referred to medic                                    | cal T  |                                |                                    | 26.P                     | lace of Death   | (Check only or                   |                            | NO I                        | 165 2 140                                      | $\dashv$ |  |
| Vita<br>ysicia<br>ysicia<br>direct   | o Be           | examiner?   | Hoonitals  | npatient 2                     | ER/Outpatien                       | t 3 DOA                  | Other:          | Nursing Hom                      | ne 5 F                     | Residence 6 🗸 C             | Ither: Scene                                   |          |  |
| n of Vital I<br>ding Physician:<br>After this certifi<br>funeral director,   | Η.             | 27. Manner of Death   | 28a. Date of (Month)   | of Injury<br>Day,Year)         | 28b. Time of                       | ′′   -                   | Injury at Work  | . ISubi                          | Describe ho                | ow injury occurred          |  |          |  |
| ion<br>ttendi<br>death.  | atio           |   | estigation May 3, 2  | 008                            | FOUND:<br>0536 hrs                 |                          | Yes 2           | No ,                             |                            |                             |  |          |  |
| Division spital or Attendi hours after death.  | Certification: | de  | uld not be   |                                | home, farm, stre                   | et, factory, offi        | ce building, e  |                                  | or Town, Sta               | ate)                        | r Rural Route Number, C                        | Jity     |  |
| ·  |                | 4 Homicide  | Physician: To the best   | Industrial                     |                                    | urrod at the time        | date and pl     |                                  |                            | nnon Street, Edn            |  |          |  |
| To the Hos<br>within 24 h<br>To the Fur<br>completely  | Medical        | Chack only Certifying   | aminer: On the basis o   | of examination                 | and/or investiga                   | ation, in my opi         | nion, death o   | ccurred at the t                 | ime, date a                | and place, and due          | to the cause(s)                                |          |  |
| To To  | Med            | 29b. Signature and title of certi                                 | and manner st<br>fier  | ated.                          |                                    | 29c. Lic                 | ense number     |                                  |                            | 29d. Date signed            | (Month, Day, Year)                             | $\neg$   |  |
|  |                | Dan m)  | Il imp.  |                                |                                    | 0                        | .C.M.E.         |                                  |                            | May 4, 2008                 |  |          |  |
|  |                | 30. Name and address of person                                    | ·  |                                |                                    | 1 Bonn 04:               | of Dalifer      | oro MD 04                        | 201                        |                             |  |          |  |
| Db.Z.  |                | Donna M. Vincenti, N<br>31. Date filed (Month, Day, Yea           |  | iedical Exa<br>gistrar's Signa | turo                               |                          | et, baltım      | ore, MD 21                       | 201                        |                             |  | $\dashv$ |  |
| Regist   |                | MAY 1   | 3 2008   | low                            | 15 A                               | ente                     |                 |                                  | -                          |                             |  |          |  |

DHMH 17 Rev 1/2001 OCME 2006

State of Maryland / Department of Health and Mental Hygiene 1- State Amend #7, 5-13-08, per FHDR, Certificate of Death

State Of Maryland / Department of Health and Mental Hygiene 2008 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 9:50 PM 8 2008 Stephen C. Springer May /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Howard Ellicott City Nursing & Rehab Ellicott City Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1⊠M 2□ F 46- 47 219 84 7742 Feb 6, 1961 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 XNo Director MD Howard Columbia 10g, Citizen of What Country? 10f, Zip Code 10e. Street and Number "natural", or items 23a or 21045 United States 6051 Majors Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by 3 ☐ Widowed 4 ☑ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) 12 Driver NOAA 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be B. Glenn Springer Gail Wolsh ပို other traumatic Health and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6051 Majors Lane Columbia, MD 21045 Jo Ann Springer/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Mem. Pk. 5-13-2008 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 21. Signature of Funeral Service Licensee Ollis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Honting **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of preuminia due to Huntingtons Examiner Aspiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner that the death certificate be executed sician and burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknown signed h Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 Onknown icate has been siç , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No certificate 1□ Yes or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Medical Certification: 1 🔀 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A
mpletely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 💢 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30641 and Back RIVEY Neck Road Balhmore Maylor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Romain Schopala: 201-109 31. Date filed (Month, Day, Year) 32. Resistrar's Signature State Registrar

08-03539 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jerry Joseph Sandy State of Maryland / Department of Health and Mental Hygiene 2008 17319 1- For State Certificate of Death Rea. No Registrar 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Day May 8, 2008 2103 hrs Medical Examiner Jerry Joseph Sandy, Sr. 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Muddy Branch Road/ Killarney Lane Rockville Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. **Funeral** oreian Months Days Hours Director 213-66-4575 51 1956 1X M 2 F Aug. 1, Country Mary land Usual Residence of Decedent 10d. Inside City Limits in, 10a, State 10b. County 10c. City, Town or Location 1 Yes 2X No permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho in jury or other fraumatic event, the Medical Examiner must be positived at our Maryland Derwood Montgomery Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16909 Briardale Road 20855 U.S.A. Funeral 14. Race - American Indian, Black 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2X No Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Erskine Sandy Barbara Jean Athey (Street and Number or Rural Route Number, City or Town, State, Zip Cod2)0879 ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address 8945 Allison Hollow Way, Gaithersburg, Maryland Jerry J. Sandy, Jr. - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Metropolitan Crematorium 5/13/08 Other Specify: Alexandria, Virginia Denation 5 22. Name and Address of Facility
Molesworth-Williams P.A., Funeral Home 21. Si mature of Funeral Service License voveit Ridge Road. Damascus. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Examiner Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED attending physician or use as the burial AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown q Unknown the o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 σ, Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy has death? performed? certificate 1 ✓ Yes 2 No 1 🗸 Yes No To the Hospital or Attending Physician: director, 25. Was case referred to medical 26.Place of Death (Check only one Be Division of Vital examiner? Hospital: 1 Other; Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this 1 V Yes ٩ 28a. Date of Injury After 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Certification: May 8, 2008 Pedestrian struck by auto Natural 2055 hrs Yes 2 V No within 24 hours after death.

To the Funeral Director: completely filled in by the f 5 Pending 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Muddy Branch Road/ Killarney Lane, Gaithersburg, Md. (Specify) Local Street Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wi

OCME 2006

31. Date filed (Month, Day Year) State 2008 Registra DHMH 17 Rev 1/2001

Ling Li, MD

32. Redistrar's Signature

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

May 9, 2008

OCME

no

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008

|   |   | I-For State<br>Registrar  |                                     | Cen                          | tificate o       | f Death       |            |             |             | R  | eg. No.      | 200            | 0 17   | 02       |  |
|---|---|---|-------------------------------------|------------------------------|------------------|---------------|------------|-------------|-------------|--|--------------|----------------|--|----------|--|
| Physicia  |   | 1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Time of Death  Month  Day  Year |                                     |                              |                  |               |            |             |             |  |              |                |  |          |  |
| ledical Examir  | ner   | Atso Savisaar   |                                     |                              |                  |               |            |             | N           | May 6, 20  | 008          | 1601           | 1645 hrs   |          |  |
|   |   | 4a. Facility Name (if not institution   | on, give street and nu              | ımber)                       |                  | 4b. City, To  | wn, or Lo  | cation of   | Death       |  | 4c. Cc       | ounty of Deat  | h  |          |  |
|   |   | 638 Wayward Drive   |                                     |                              |                  | Annapo        | olis       |             |             | Anne Arundel   |              |                |  |          |  |
| Funeral   |   | 5. Social Security Number   | 6. Sex                              | 7. Age (In yrs. Ia           | st birthday)     | If Under      | 1 Year     | If Under    | 24Hrs.   8  | rs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or |              |                |  |          |  |
| Director  |   | 150-26-1224   | 1XXM 2 F                            |                              | 75 Yr            | Months        | Days       | Hours       | Min.        | 4/25/  | 1033         | Forei          | <sup>gn</sup><br><sup>ountry)</sup> Eston        | ia       |  |
|   |   |   | 14.4M 2 F                           |                              | / 5 Yr           | s             | لـــا      |             |             | 4/23/  | 1933         |                | ESCOII   | La       |  |
| <u>*</u>  | ŀ   | Usual Residence of Decedent  10a. State 10b. County   | <u> </u>                            | 10c City                     | Town or Loca     | tion          |            |             |             |  |              |                | 10d. Inside City                                 | Limits   |  |
| w any   |   |   | e Arundel                           |                              |                  | polis         |            |             |             |  |              |                | 1 Yes 2X   |          |  |
| and Sho   | 5   |   |                                     |                              |                  | •             |            |             |             |  |              |                |  |          |  |
| Maryland<br>28a-f show  | Director  | 10e. Street and Number  |                                     |                              |                  | 10f. Zip C    |            |             |             |  | 10g. Citizen | of What Cou    | ıntry?   |          |  |
| a or  | 히   | 638 Wayward DR  |                                     |                              |                  |               | 2          | 1401        |             |  | USA          |                |  |          |  |
| with is 23  | 蔨   | 11. Marital Status  |                                     | cedent Ever in U.            |                  | as Decedent   |            |             |             |  | 0- 14.       |                | rican Indian, Black                              |          |  |
| item item   | Funeral   | 1 Never Married 2 XX Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc  |                                     |                              |                  |               |            |             |             |  |              | White, etc.    |  |          |  |
| i, or   |   | 3 Widowed 4 Div   |                                     |                              | Sp               | ecify: V      | √hite      |             |             |  |              |                |  |          |  |
| urs ad<br>umin  | G 15 Decident Sequentian (Specific set in bishes are also completed) 160 Decedent Liquid Occupation (Sixe kind of |   |                                     |                              |                  |               |            |             |             |  | 16b. Kind    | of Business    | /Industry  |          |  |
| 2 hou   | Completed   | Elementary/Secondary (0-12)   | College (                           | 1-4 or 5+)                   | •                | nost of worki | •          |             |             | )  |              |                |  | - 2      |  |
| 5-0036<br>led within 72 ho<br>tygiene.<br>other than "n:<br>the Medical Ex  | 희   |   | 5 <del>+</del>                      | •                            | Elect            | rical         | Eng        | inee        | r           |  | Ae           | rospac         | ce   |          |  |
| Sien gien   | 5   | 17. Father's Name (First, Middle  | L Last)                             |                              |                  |               | 118        | .Mother's   | Name (Fi    | irst, Middle,  | Maiden Su    | rname)         |  |          |  |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other than<br>ent, the Medica  | Be  | 17. Father's Name (First, Middle<br>E <b>lmar J. Savis</b> a                                  | ar                                  |                              |                  |               | Α          | rmilo       | da En       | nilie  | Ko1k         | ,              |  |          |  |
| 212<br>ould be<br>Ments<br>mark   | 밁   | 19a. Informant's Name/Relations   | shin (Type Print )                  |                              | 19h Mailir       | ng Address    | (Street :  | and Numb    | er or Rur   | al Route No  | mber City    | or Town, Stat  | te, Zip Code)                                    | -        |  |
| MD 2<br>d 2 shou<br>lth and l<br>n 27 is r<br>aumatic   | -   | Inge Savisaar   | Spouse                              |                              |                  | laywar        | ,          |             |             |  | •            |                | ,,   |          |  |
| nd 2<br>salth:  |   | 20a. Method of Disposition  | Spouse                              |                              | Place of Dispo   |               |            |             |             | Date   |              |                | or Town, State                                   |          |  |
| S la  |   | 1 Burial 2 XXCremation  | n 3 Removal f                       |                              | crematory or o   |               | 3 01 00/11 | ,,,         | _           | , u.o  |              |                | ,  |          |  |
| more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once  |   | 4 Donation 5 Other S  |                                     | Met                          | ro Cre           |               |            |             |             | 17/2008 Baltimore, MD                                    |              |                |  |          |  |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite  |   | 21. Signature of Funeral Service  |                                     |                              | 22.              | Name and A    | ddress o   | of Facility | larde       | esty I   | unera        | 1 Home         | P.A.   |          |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medica  | 1   | 18 7.09   | <b>3</b>                            |                              | 12               | Ridge         | ely .      | Ave.        | Ann         | napoli   | s, MD        | 21401          | L  |          |  |
| Physician   |   | 23a. Part I. Enter the disease, or  | r complications that                | caused the death.            | . Do not enter   | the mode of   | dying, s   | uch as car  | rdiac or re | espiratory a   | rrest, shock | , or heart     | Approximate In                                   |          |  |
| /Medical  |   | failure. List only one cause  | A 4la a a a a a l a                 | erotic Cardiov               | accular Di       | 92592         |            |             |             |  |              |                | Between Onse<br>Death                            | et anu   |  |
| ⊂xaminer  |   | Immediate Cause (Final disease or condition resulting in death)                               |                                     | a consequence of             |                  | 36436         |            |             |             |  |              |                | <del>                                     </del> |          |  |
|   |   |   | h                                   |                              | .,               |               |            |             |             |  |              |                |  |          |  |
|   | 힏   | Sequentially list conditions, if any, leading to immediate                                    | Due to (or as                       | a consequence of             | f):              |               |            |             |             |  |              |                |  |          |  |
|   | Examiner  | cause. Enter Underlying Cause (Disease or injury that initiated                               | С.                                  |                              |                  |               |            |             |             |  |              |                |  |          |  |
| si d  | xa  | events resulting in death) Last   | Due to (or as                       | a consequence of             | f):              |               |            |             |             |  |              |                |  |          |  |
| ecute<br>and<br>- tran  |   |   | <b>_</b>                            |                              |                  |               |            |             |             |  |              |                |  |          |  |
| 760,<br>cate be ex<br>physician<br>the burial   | n/Medical   | UNPENDED  | AMENDED                             |                              |                  |               |            |             |             |  |              |                |  |          |  |
| 68760,<br>certificate be<br>nding physici<br>se as the buri   | § S   | IF FEMALE:<br>23b. Was decedent pregnant in t   | '                                   | , outcome of preg            | nancy            |               |            | _           |             |  |              | Date of delive |  |          |  |
| 688<br>ertifi<br>ding   | ja.   | past 12 months?   | l Prive                             | birth<br>nant at time of de  | oth =            | etal death    | 3          | Ectopic     | pregnanc    | ;y   | I M          | onth           | Day Ye   | ar       |  |
| Box 687 e death certific the attending of   | sic   | 1 Yes 2 No 9 Ur   |                                     |                              | eath 5 (         | Other (Speci  | fy)        |             |             |  |              |                |  |          |  |
| y the de  | Physiciar   | Part II. Other significant condi  |                                     |                              | oculting in the  | underlying    | cauco di   | on in Par   | + l         | 23e Did  | tobacco us   | e contribute t | to the cause of dea                              | th?      |  |
| P.O.  | by  |   | •                                   | to death but not n           | esulariy iri are | diacitying    | Jause gr   | ven mi a    |             |  |              |                | obably 4 Unk                                     |          |  |
| ords, P.C<br>w requires that<br>is been signed b  | b   | Chronic alcohol abus  | se                                  |                              |                  |               |            |             |             |  |              |                |  | -15-121  |  |
| regr  | Completed   |   |                                     |                              |                  |               |            |             |             | 24a. Wa<br>aut   | s an<br>opsy |                | autopsy findings av<br>completion of cau         |          |  |
| e law<br>e has  | 티   |   |                                     |                              |                  |               |            |             |             | per  | formed?      | death?         | ?  | No       |  |
| tal Reco  |   | 05 14/  | -1                                  |                              |                  | 2             | 6 Place    | of Dooth (  | Check on    |  | 2140         | · •            | 163 2  | 140      |  |
| of Vital Records, g Physician: The law require ther this certificate has been at meral director, page 2 should I  | Be  | 25. Was case referred to medic examiner?  | Hospital:                           |                              | TD/0             |               | 10         | Other       |             | Home 5   | Booldons     | e 6 🗸 Oth      | ari Saana  |          |  |
| Physical distribution   | ٩   | 1 V Yes 2 No  |                                     | Inpatient 2                  | ER/Outpatie      |               |            | at Work?    |             |  | e how injury |                | ier, Scerie                                      |          |  |
| ision of ' Attending Ph r death. cctor: After t   |   | 27. Manner of Death  1 ✓ Natural 5 □ Por  | (Mon                                | e of Injury<br>th, Day,Year) | 28b. Time o      | r injury 2    |            |             |             | ou. Describ  | e now injury | occuneu        |  |          |  |
| Division all or Attendiurs after death.  al Director: A   | aţic  |   | nding<br>estigation                 |                              |                  |               |            | es 2        |             |  |              |                |  |          |  |
| ivisior  or Attendate death  Director: d in by the  | ij  | 3 Suicide 6 Cou   | uld not be 28e. Pla                 | ice of Injury - At h         | ome, farm, str   | eet, factory, | office bu  | ilding, etc | c. 28       | 8f. Location<br>or Town                                  |              | Number or I    | Rural Route Numbe                                | er, City |  |
| pital Di murs a Tilled  | Certification:  |   | ermined (Specif)                    | )                            |                  |               |            |             |             |  |              |                |  |          |  |
| Hosp<br>24 ho<br>Fum<br>tely f  |   | 29a. Certifier 1 Certifying F   | Physician: To the b                 | est of my knowled            | ge, death occ    | urred at the  | time, dat  | e and plac  | ce, and du  | ue to the ca   | use(s) and   | manner as st   | tated.   |          |  |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the fineral director, page 2 should be detached for use as the burial - transil | Medical   | one) 2 Medical Ex   | aminer: On the basis                | of examination a             | nd/or investig   | ation, in my  | opinion,   | death occ   | curred at t | he time, da  | te and place | e, and due to  | the cause(s)                                     |          |  |
| \$ £ \$ £ 8   | Me  | 29b. Signature and title of certifi   |                                     | Sparce .                     |                  | 29c.          | License    | number      |             |  | 29d. Da      | ate signed (A  | Month, Day, Year)                                |          |  |
|   |   | 1/1/2000  | 1 74                                |                              |                  |               | O.C.N      | 1.E.        |             |  | May          | 7, 2008        |  |          |  |
| 1. 1  | 1   | cavvvv  | 21                                  |                              | 32-1             |               |            |             |             |  |              |                |  | _        |  |
| UX XX   | M   | 30. Name and address of perso   | n who complete ca<br>Assistant Medi |                              |                  | enn Street    | Ralfi      | more M      | MD 2120     | 01   |              |                |  |          |  |
| 010   |   | <u></u>   |                                     |                              |                  |               | ., Jaini   |             | 2121        |  |              |                |  |          |  |
|   | ate   | 31. Date filed (Month, Day, Year,   |                                     | strar's Signati              | ure<br>#         | Land.         |            |             |             |  |              |                |  |          |  |
| Regist  | ucu   |   | W LUUU                              | Glober                       | Kr. K            | 200           |            |             |             |  |              |                |  |          |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State
Registrar
Certificate of Death
Reg. No.

1. Decedent's Name (First, Middle, Last)
Guy Phillip Sullivan

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

2008 17321

2. Date of Death
Month Day
May 7, 2008

Year 1610 hrs

|  |  | Registrar   |   | Cert       | illicate o              | Dec                    | uri                            |              |           |                                   | Reg. No.         |                     |                |  |
|--|--|---|---|------------|-------------------------|------------------------|--------------------------------|--------------|-----------|-----------------------------------|------------------|---------------------|----------------|--|
| Physician<br>ledical Examine   | er   | Decedent's Name (First, Middle Guy Phillip Sul  | llivan  |            |                         |                        |                                |              |           | Date of Dea<br>Month<br>May 7, 20 | Day              | Year                | 3              | . Time of Death<br>1610 hrs                    |
| ,  |  | 4a. Facility Name (If not institution<br>1664 Preakness Drive   | ,   |            |                         |                        | Town, or Lo                    | ocation of I | Death     |                                   |                  | ounty of D          |                |  |
| Funeral  | 7  | 5. Social Security Number (   | 6. Sex 7. Age (                                     | In yrs. la | st birthday)            | If Ur                  | der 1 Year                     | If Under 2   | 24Hrs.    | 8. Date of B                      | rth(MM/D         |                     |                | lace (State or                                 |
| Director   |  |   | 1XX M 2 F   |            | 69 <sub>Yr</sub>        | Mon                    | ths Days                       | Hours        | Min.      | 8/21                              | /193             | 8 <sup>F</sup>      | oreign<br>Coun | try) NY  |
| any  | -  | Usual Residence of Decedent  10a. State 10b. County   | Inc   | c City     | Town or Loca            | tion                   |                                |              |           |                                   |                  |                     |                | 0d. Inside City Limits                         |
| <u> </u>   | 1  | · · · · · · · · · · · · · · · · · · ·   | Arundel   |            | ambril                  |                        |                                |              |           |                                   |                  |                     |                | 1 Yes 2XX No                                   |
| e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland stells and Mental Hygiene.  Titem 27 is marked other than "natural", or items 23a or 28a-f she ritem 27 is marked other than "natural", or items 23a or 28a-f she ritaumatic event, the Medical Examiner must be notified at once To Be Completed by Eringeral Director  | Direct   | 10e. Street and Number<br>1664 Preakness  | Dr.   |            |                         | 10f. Zip Code<br>21057 |                                |              |           |                                   |                  | en of What<br>US    |                | y?   |
| ath with items 23  | 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - America White, etc. 15. January 19. Widowed 4 XXDivorced of Yes, Give Yeer Or Dates: 19. Was Decedent Ever in U.S. 11. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - America White, etc. 15. January 19. Widowed 4 XXDivorced of Yes, Give Yeer Or Dates: 16. Was Decedent to Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. Was Decedent Ever in U.S. 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. 19. Was Decedent Ever in U.S. 19. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Was Decedent Ever in U.S. 19. Was Dec |   |   |            |                         |                        |                                |              |           |                                   | n Indian, Black, |                     |                |  |
| after de rall', or i   |  |   |   |            |                         |                        |                                |              |           |                                   |                  | hite                |                |  |
| 72 hours<br>n "natur<br>al Exam  | ered   | 15. Decedent's Education (Speci<br>Elementary/Secondary (0-12)  | ify only highest grade compl<br>College (1-4 or 5+) |            | 16a. Decede<br>during r |                        | al Occupatio<br>orking life. [ |              |           |                                   | 16b. Kir         | nd of Busin         | ess/Ind        | lustry   |
| 0036 within 72 iene.   | 15. Decedent's Education (Specity only highest grade completed)    16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)   16b Rind of Business/Industrial Control of  |   |   |            |                         |                        |                                |              |           |                                   |                  | r Rental            |                |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica   |  | 17. Father's Name (First, Middle, Last) Anthony Sullivan  18. Mother's Name (First, Middle, Maiden Surname) Monica Shearing   |   |            |                         |                        |                                |              |           |                                   |                  |                     |                |  |
| MD 21. d 2 should 1 lith and Mer n 27 is mar n m 27 is mar   |  |   |   |            |                         |                        |                                |              |           |                                   |                  | Zip Code)           |                |  |
| ore, Nes 1 and of Health If item   |  | 20a. Method of Disposition  |   | 20b. P     | Place of Disno          | sition (N              | ame of ceme                    | etery        |           | Date                              | 20c Lo           | cation - Ci         | ty or T        | own, State                                     |
| Baltimore, pernit. Pages I an Department of Hee Important: If ite  |  | 1 X Burial 2 Cremation 4 Donation 5 Other Spe   | ecify:  | Our        | rematory or o           |                        |                                |              |           |                                   |                  |                     |                |  |
| Bally permit post Importing injury   | 1  | 21. Sanature of Funeral Service C   | Civers e  |            |                         |                        |                                |              |           | esty I<br>napoli                  |                  |                     |                | P.A.   |
| Physician<br>/Medical  | I  | 23a. Part I. Enter the disease, or of failure. List only one cause of the control of the cont | complications that caused the                       | e death.   | Do not enter            | the mod                | e of dying, s                  | uch as car   | diac or r | espiratory ar                     | rest, shoc       | k, or heart         |                | Approximate Interval<br>Between Onset and      |
| xaminer  |  | Immediate Cause (Final disease or condition resulting in death)   | a. Hypertensive Athe                                |            |                         | liovaso                | ular Dise                      | ase          |           |                                   |                  |                     |                | Death  |
|  |  | Sequentially list conditions,   | b   |            |                         |                        |                                |              |           |                                   |                  |                     |                |  |
| ted Insit  |  | if any lossing to in modele<br>cause. Enter Underlying Cause<br>(Disease or injury that initiated   | c.  Due to (or as a consequence)                    |            |                         |                        |                                |              |           |                                   |                  |                     |                |  |
| ficate be executed g physician and transit the burial - transit  |  | events resulting in death) Last   | d.  |            | ·                       |                        |                                |              |           |                                   |                  |                     |                |  |
| 68760,<br>ertificate be execu<br>ding physician and<br>eas the burial - tra  | ğ  | UNPENDED  | AMENDED   |            |                         |                        |                                |              |           |                                   | Lan              |                     |                |  |
| 5876<br>artificat<br>ling ph   |  | IF FEMALE:<br>23b. Was decedent pregnant in the<br>past 12 months?  | 23c. If yes, outcome                                | of pregn   |                         | etal deat              | h 3                            | Ectopic p    | regnand   | ;y                                |                  | Date of de<br>Nonth | elivery<br>Da  | y Year   |
| (ecords, P.O. Box 68760, The law requires that the death certificate be executed are has been signed by the attending physician and age 2 should be detached for use as the burial - transitional by Dhysician Madical Expendidual to Dhysician Madical Expendical Expendical Expensive Computers of the physician for the phy | ysicia   | 1 Yes 2 No 9 Unkr   | nown g Unknown                                      | ne of dea  | oth -                   | ther (Sp               |                                |              |           |                                   |                  |                     |                |  |
| O. E at the od by the etached  |  | Part II. Other significant condition  | ons contributing to death b                         | ut not re  | sulting in the          | underlyi               | ng cause giv                   | en in Part   | l.        | 1                                 |                  |                     |                | e cause of death?                              |
| S, P.(   |  | Chronic obstructive pu  | ulmonary disease                                    |            |                         |                        |                                |              | _         |                                   |                  |                     |                | bly 4 Unknown                                  |
| of Vital Records,  bg Physician: The law requirer ther this certificate has been signeral director, page 2 should be   | E L  | •   |   |            |                         |                        |                                |              |           | 24a. Was                          |                  | pric                |                | psy findings available<br>mpletion of cause of |
| DZ [   | รุ   |   |   |            |                         |                        |                                |              |           |                                   | 2 No             |                     | Yes            | 2 No   |
| Vital Recysician: The his certificate director, page   |  | 25. Was case referred to medical examiner?  | [Hospital: 1 Innations                              |            |                         |                        |                                | of Death (C  | heck on   | ly one)                           |                  |                     | _              |  |
| Physical direction   | 2 -  | 1 ✓ Yes 2 No<br>27. Manner of Death   | i inpatient   |            | ER/Outpatien            |                        |                                |              |           | Home 5                            |                  | ce 6 🗸              |                | Scene<br>                                      |
| Sion of Nattending Phydeath. ctor: After the funeral   |  | 1 Natural 5 Pendi   | 28a. Date of Injury<br>(Month, Day,Year<br>ing      | ')         | 28b. Time of            | injury                 | 28c. Injury                    | atwork?      |           | 8d. Describe                      | now injur        | y occurred          |                |  |
| Bre Zi   |  |   | I not be 28e. Place of Injur                        | y - At ho  | me, farm, stre          | et, facto              | ry, office bu                  | ilding, etc. | 2         | 8f. Location<br>or Town,          |                  | d Number            | or Rura        | Route Number, City                             |
| To the Hospital within 24 hours. To the Funeral completely filled  |  | 29a. Certifier 1 Certifying Phy   | ysician: To the best of my k                        |            |                         |                        |                                |              |           |                                   |                  |                     |                |  |
| T N S  | ₽  | 29b. Signature and title of certifier   | and manner stated.                                  |            |                         | 2                      | 9c. License                    | number       |           |                                   | 29d. D           | ate signed          | (Mont          | h, Day, Year)                                  |
| 100  | 1  | Pote au   | - Holle   |            | 5                       |                        | O.C.M                          | .E.          |           |                                   | May              | 8, 2008             |                |  |
| 400  |  | 30. Name and address of person v<br>Patricia Aronica-Pollak   |   | ,          | •                       | 111                    | Penn Stre                      | eet, Balt    | imore,    | MD 2120                           | 01               |                     |                |  |
| State<br>Registra  | e  | 31. Date filed (Month, Day, Year) MAY 12  | 2008 32. Registrar's                                |            |                         | المعا                  |                                |              |           |                                   |                  |                     |                |  |
|  | -  | \$115 L 10  |   |            |                         | - /                    |                                |              |           |                                   |                  |                     |                |  |

DHMH 17 Rev 1/2001 OCME 2006

|                     |   |                | For State Registrar  | State of Ma                       | aryland / [                         | Depa<br><i>Cer</i> | rtment of H  | ealth and M<br>Death                     | lental Hygi                        | ene 200                   | 18  | 17322                               |
|---------------------|---|----------------|--|-----------------------------------|-------------------------------------|--------------------|--|--|------------------------------------|---------------------------|---|-------------------------------------|
|                     |   |                | Decedent's Name (First, Middle,  |                                   |                                     |                    |  |  | 2. Date of Death                   | 1                         |   | 3. Time of Death                    |
| 5                   | Physici   |                | Stella B.  | Shaffer                           |                                     |                    |  |  | Month<br>May                       | 10 200                    | Year<br>N.R                                     | 9:10 P. <sup>M</sup>                |
|                     | /Medic  |                | 4a. Facility Name (If not institution,                                 |                                   |                                     |                    | 4b. City, Town, or   | Location of Death                        | Titay                              | 4c. County of             |   | 7.10 1.                             |
| Ø.                  | Examili   | ie.            | 389 Dennett Roa  | d                                 |                                     |                    | 0ak1an   | d  |                                    | Garre                     | ett   |                                     |
| and the same        | Funeral   |                |  | . Sex 7. Ag                       | je (In yrs. last bir                | thday)             | If Under 1 Year  | If Under 24 Hrs.                         | 8. Date of Birth                   |                           | 9. Birthpla                                     | ce (State or Foreign                |
| 10                  | Director  |                | 213-12-9174  | 1 □ M 2 🕅 F                       | 88                                  | Yrs.               | Months Days  | Hours Min.                               | (Month, Day,<br>March 2            |                           | Couintry<br>Mary                                |                                     |
|                     | D   |                | Usual Residence of Decedent  |                                   |                                     |                    |  |  |                                    |                           |   |                                     |
|                     | rylan<br>how<br>Lat   | _              | 10a. State 10b. County   |                                   | 10c. City, Tow                      | n or Lo            | cation   |  |                                    |                           | 100   | d. Inside City Limits               |
|                     | e Ma<br>sa-f s<br>tiffiec   | cto            | MD Garre   | tt                                | 0akla                               | nd                 |  |  |                                    |                           |   | 1 XYes 2 No                         |
|                     | # #<br>or 28  | Director       | 10e. Street and Number   |                                   |                                     |                    | 10f. Zip Code  |  | 10                                 | g. Citizen of Wh          | nat Country                                     | y?                                  |
|                     | 23a<br>ust b  | ra             | 389 Dennett Roa  | .d                                |                                     |                    | 21550  |  |                                    | United S                  |   |                                     |
|                     | ems<br>er m   | Funeral        | 11. Marital Status   | 12. Was Decedent<br>Armed Forces? |                                     | 13. V              | Was Decedent of Hi<br>f Yes, specify Cuba                        | spanic Origin? (Sp<br>n, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.)   |                           | <ul> <li>Americar</li> <li>White, et</li> </ul> | ,                                   |
| 36                  | be filed within 72 hours after death with the Maryland the Hygiene.  d ethylgiene.  d other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at |                | 1 Never Married Marrie   | If Yes, Give                      | No                                  | -                  | I∐Yes 2 <b>X</b> No  | Specify:                                 |                                    | Specify:                  | TT1   |                                     |
| 8                   | urai"   | d by           | 3 ☐ Widowed 4 ☐ Divorced   | Year or Dates:                    | 10-                                 | <br>               | tantia tiawal Osawa  | tion.                                    |                                    |                           | Whit  |                                     |
| 5                   | "nat  | Completed      | 15. Decedent's<br>(Specify only highest                                | Education<br>grade completed)     | 16a.                                | (Give              | lent's Usual Occupa<br>kind of work done o<br>DO NOT use retired | ation<br>Juring most of work             | ring                               | 16b. Kind of Bus          | mess/mau  | istry                               |
| 12                  | withir  | 립              | Elementary/Secondary (0-12)  | College (1-4or                    | 5+)                                 |                    | memaker  | /  |                                    | Own I                     | Home  |                                     |
| 7                   | filed within<br>Hygiene.<br>other than '<br>ent, the Me   |                | 17. Father's Name (First, Middle, La                                   | l<br>ast)                         |                                     | 110                | memaker  | 18. Mother's Nam                         | e (First, Middle, N                |                           |   |                                     |
| auc                 | e d d d   | Be             | Russell H. Leig  | •                                 |                                     |                    |  | Laura S                                  |                                    |                           |   |                                     |
| Maryland 21215-0036 | d 2 should be the and Mental   7 is marked o traumatic eve  | 은              | 19a. Informant's Name/Relationship                                     |                                   | 195                                 | Mailin             | ig Address (Street a   |  |                                    | City or Town S            | tate Zin (                                      | Code)                               |
| Ma                  | d 2 in a 7 is tra   |                | Mr. Q. Nordeck   | ' '                               |                                     |                    |  |  |                                    |                           | , , ,   | ,                                   |
| d)                  | s 1 and 2<br>if Health<br>item 27 i   |                | 20a. Method of Disposition   | bharrer, in                       |                                     |                    | Dennett sition (Name of natory or other place                    |  |                                    | 20c. Location - C         | ity or Tow                                      | n, State                            |
| JO.                 | ages<br>nt of<br>t: If it   |                | 1 Burial 2X Cremation  |                                   | 1                                   |                    |  | 1  | 2/2000                             | 0 11                      | . 1   | 100                                 |
| Baltimore,          | permit. Pages ' Department of I Important: If ite any injury or ot  |                | 4 □ Donation 5 □ Other (Special Signature of Funeral Service Li        |                                   | Lumbe                               |                    | nd Cremat<br>2. Name and Addres                                  |  | 2/2008                             | Cumberla                  | and,  | MD                                  |
| Ва                  | permi<br>Depa<br>Impo<br>any it   |                | 21. Olgitature of Curietal October 21                                  | (1. · T                           |                                     | _                  | David A.   | Burdock<br>cond St.                      | Funeral                            | Home, l                   | P.A.  |                                     |
| 1                   |   | $\vdash$       | 23a. Part1. Enter the disease, or c<br>shock, or heart failure. List o | omplications that cause           | d the death. Do                     | not ent            | er the mode of dvin  | d. such as cardiac                       | or respiratory arre                | d <u>ا MD_</u> کر<br>est. | ,   | Approximate                         |
|                     |   |                | shock, or heart failure. List o  | nly one cause on each li          | ne.                                 |                    |  |  |                                    |                           |   | Interval Between<br>Onset and Death |
|                     | Physician<br>/Medical   | ш              | disease or condition resulting in death)                               | a. 417h                           | emer                                | 5                  | deme   | rfia                                     |                                    |                           |   | 542                                 |
|                     | Examiner  | Ш              |  | Due to (or as                     | a consequence                       | or):               |  |  |                                    |                           |   |                                     |
| H.                  |   | <u>.</u>       | Sequentially list conditions,  | b. — Due to (or as                | a consequence                       | of):               |  |  |                                    |                           |   |                                     |
|                     | nsit  | 듩              | cause. Enter Underlying Cause (Disease or injury                       |                                   |                                     |                    |  |  |                                    |                           |   |                                     |
| ,                   | be executed<br>sician and<br>burial-transit   | Examiner       | that initiated events<br>resulting in death) Last                      | CDue to (or as                    | a consequence                       | of):               |  |  |                                    |                           |   |                                     |
| 8760,               | The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit  | dical          |  | d                                 |                                     |                    |  |  |                                    |                           |   |                                     |
| 89                  | fficate<br>g physi<br>as the b  | edic           |  |                                   |                                     |                    |  |  |                                    |                           |   |                                     |
| Вох                 | eath certific<br>attending p<br>for use as f  | Ž              | IF FEMALE:<br>23b. Was decedent pregnant                               | 23c. If yes, outcome              | pf pregnancy                        | ۰۰                 | Te   |  |                                    | 23d. Date                 | of deliver                                      | у                                   |
| Ď                   | death<br>e atte   | icia           | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                               | 4□Pregnant a                      | 2 ☐ Fetal death<br>at time of death |                    | ]Ectopic pregnancy<br>] Other <i>(specify)</i>                   |  |                                    | Mon                       | th [  | Day Year                            |
| P.0                 | the sy the  | Physician/Me   | 9 ☐ Unknown  | 9□Unknown                         |                                     |                    |  |  |                                    |                           |   |                                     |
| Д.                  | res that the de<br>signed by the a<br>be detached   | by P           | Part II. Other significant condition                                   | s contributing to death t         | out not resulting i                 | n the u            | nderlying cause give   | en in Part I.                            | 23e. Did tob                       | acco use contril          | oute to the                                     | e cause of death?                   |
| ğ                   | w require<br>been sig<br>should b   |                | HONTIC   | stenasi                           | 5                                   |                    |  |  | 1 □ Ye                             | s 2 No                    | 3□ Proba  | ıbly 4 ∐Unknown                     |
| or Vital Records,   | law re<br>as bee<br>2 sho   | Completed      |  |                                   |                                     |                    |  |  | 24a. Was ai                        |                           | ere autop                                       | sy findings available               |
| æ                   | The la  | mo             |  |                                   |                                     |                    |  |  | autops<br>perforr<br>1□ Yes 2      | ned? de                   | eath?   | pletion of cause of                 |
| ta                  |   | 0              | 25. Was case referred to medical                                       | 11                                |                                     |                    |  | 26. Place of Dea                         | th (Check only on                  |                           |   | 20110                               |
| >                   | Physician:<br>this certific<br>ral director,  | To B           | examiner?<br>1 ☐ Yes 2 ☐ No  | Hospital: 1 ☐ Inpati              | ent 2 ☐ ER/O                        | utpatier           | nt 3 DOA Othe  | er:<br>4 Nursing H                       | ome 5 Reside                       | ence 6 □Othe              | r (Specify)                                     | )                                   |
|                     |   |                | 27. Manner of Death  | 28a. Date of Inj<br>(Month, Da    |                                     | Time of            | f 28c. Injur<br>Worl   |  | 28d. Describe ho                   |                           |   |                                     |
| <u>i</u>            | Attending r death. ector: After on the fune   | atio           | 1 ☑ Natural 5 ☐ Pending<br>2 ☐ Accident investiga                      |                                   | zy rear)                            | iiijaiy            |  | Yes 2 □ No                               |                                    |                           |   |                                     |
| Division            | i or Attendafter death.  Director: A  | iţi            | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin                      | 20e. Place of iti                 | jury - At home, fa                  | arm, str           | eet, factory, office   |  | 28f. Location (St.<br>City or Town | reet and Numbe            | r or Rural                                      | Route Number,                       |
|                     | tai or<br>s afte<br>ai Dir<br>ed in   | Certification: |  |                                   | (=                                  |                    |  |  |                                    | ,,,                       |   |                                     |
|                     | hour<br>hour<br>uner  |                |  | Physician: To the best            |                                     |                    |  |  |                                    |                           |   |                                     |
|                     | To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the  | Medical        | one)   | and manner s                      |                                     |                    |  |  |                                    |                           |   |                                     |
|                     | Vith<br>To 1  | Σ              | 29b. Signature and title of certifier                                  |                                   | . 6                                 |                    | 29c. Licens  | e number                                 | 2                                  | 9d. Date signed           | (Month, D                                       | Day, Year)                          |
|                     |   |                | 1690   | 1                                 | gre.                                | -                  | 1140   | 1464                                     |                                    | 112/0                     | 18  |                                     |
|                     |   | In             | 30. Name and address of person w                                       |                                   |                                     |                    |  |  |                                    |                           |   |                                     |
|                     |   | 10             | Dr. Sotiere Sa   |                                   |                                     | h 4                | th Street  | , Oaklan                                 | d, MD 21                           | 550                       |   |                                     |
|                     |   | ate            | 31. Date filed (Month, Day, Year)                                      |                                   | rar's Signature                     | A                  | Lacros & 1   |  |                                    |                           |   |                                     |
|                     | Regist  | rali           | MAY 1  | 2 TANK                            | Property States                     | A. A.              | 13 LE 18 19 19 19 19 19 19 19 19 19 19 19 19 19                  |  |                                    |                           |   |                                     |

|            |  |                | For State Registrar  | State of Ma  |                                | -                    | rtment of H<br>t <i>ificate of L</i>                         |                          |                              | _                                 | _                   | 200                      | 18                       | 17323  |
|------------|--|----------------|--|--|--------------------------------|----------------------|--|--------------------------|------------------------------|-----------------------------------|---------------------|--------------------------|--------------------------|--|
| -          | Physici  | an.            | 1. Decedent's Name (First, Middle, L   | .ast)  |                                |                      |  |                          |                              | 2. Date of De<br>Month            | ath                 |                          |                          | 3. Time of Death                               |
|            | /Medic   |                | Sadie Mae  | Sipe   |                                |                      |  |                          |                              | Мау                               | 1<br>1              |                          | 2008                     | 11:30A™  |
| 2          | Examin   | er             | 4a. Facility Name (If not institution, g   |  |                                |                      | 4b. City, Town, or   |                          |                              |                                   | 40                  | . County o               |                          |  |
|            |  |                | 340 Sun Park La 5. Social Security Number 6.   |  | e (In yrs. last birt           | th day)              | Hunti  | -                        |                              | 8. Date of Bir                    | th                  | Cal                      | vert                     | 200 (State or Foreign                          |
| As a       | Funeral<br>Director  |                | 220-96-5360  | 1□M 2∏F  |                                | Yrs.                 | Months Days  | Hours                    | Min.                         | (Month, Da                        | v. Year             | 926                      | Mary                     | ace (State or Foreign<br>try)<br>Land          |
|            | and w  |                | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town                | or Loc               | ation  |                          |                              |                                   |                     |                          | 10                       | Od. Inside City Limits                         |
|            | Maryl<br>-f sho<br>fled a  | tor            | MD Calver  | t  | Hır                            | ntii                 | ngtown   |                          |                              |                                   |                     |                          |                          | 1 ☐ Yes 2 🛣 No                                 |
|            | r 28a  | Director       | 10e. Street and Number   |  |                                |                      | 10f. Zip Code  |                          |                              |                                   | 10g. Ci             | tizen of W               | hat Count                | try?   |
|            | th wit   | alD            | 340 Sun Park La  | ne   |                                |                      | 2063   | 39                       |                              |                                   |                     | Unit                     | ed St                    | tates  |
|            | tems   | Funeral        | 11. Marital Status   | 12. Was Decedent 8<br>Armed Forces?                                |                                | 13. W                | as Decedent of Hi<br>Yes, specify Cuba                       | ispanic O<br>ın, Mexica  | rigin? (Spec<br>an, Puerto F | cify Yes or No<br>Rican, etc.)    | )-                  |                          | - America                |  |
| 215-0036   | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u> | by             | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates:                    | No.                            | 1                    | □Yes 2🎇 No   | Specify                  | <i>/</i> :                   |                                   |                     | Specify:                 | w]                       | hite   |
| 2<br>-     | 72 h<br>"natu<br>dical   | Completed      | 15. Decedent's (Specify only highest of  | Education<br>grade completed)                                      | 16a.                           | Decede<br>(Give k    | ent's Usual Occup<br>ind of work done o<br>O NOT use retired | ation<br>during mo       | st of workin                 | g                                 | 16b. k              | Kind of Bu               | siness/Ind               | ustry  |
|            | within   | mpl            | Elementary/Secondary (0-12)  | College (1-4or 5   |                                |                      | <i>0 NOT u</i> se <i>retired</i><br>emaker                   | 1)                       |                              | -                                 |                     | vn ho                    | mo                       |  |
| 7 0        | filed Hygie  |                | 17. Father's Name (First, Middle, La   | st)  |                                | HOME                 | emakei   | 18. Moth                 | ner's Name                   | (First, Middle,                   |                     |                          |                          |  |
| yland      | lid be<br>lental<br>ked c  | To Be          | Martin   | Brightwell   |                                |                      |  |                          | tie                          |                                   | zabe                |                          | •                        | owler  |
| ar∕        | shou<br>and M<br>s mar<br>umat   | -              | 19a. Informant's Name/Relationship   |  |                                | Mailing              | Address (Street  |                          |                              |                                   |                     |                          | State, Zip               | Code)  |
| , Mar      | and 2<br>salth a<br>n 27 is  |                | Darla'Ray Sipe,  | daughter i   | n law                          | 99                   | 2 Tequila  | a Str                    | aight                        | Drive                             | , Lo                | othia                    | n, MI                    | 20711  |
| o<br>G     | of He  |                | 20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3  | □Removal from State  | 20b. Place of<br>cemeter       | Dispos<br>y, crem    | ition (Name of<br>atory or other place                       | ie) ;                    | Da                           | ate                               | 20c. L              | ocation -                | City or To               | wn, State                                      |
| Ē          | Pag<br>Iment<br>Iant:  |                | 4 Donation 5 Other (Spe  | cify)  | Southe                         | _                    | Mem. Grd   |                          |                              | 5-2008                            |                     | nkirk                    |                          |  |
| Baitimore, | Depar<br>Import<br>any In  |                | 21. Signature of Funeral Service Lic   | ensee  | >                              | 22.                  | Name and Addres  |                          |                              | usch F                            |                     |                          |                          | P.A.<br>MD 20736                               |
| F          |  |                | 23a. Part1. Enter the disease, or co   | mplications that caused  | the death. Do n                | not ente             |  |                          |                              |                                   |                     | =, Ow                    | Ings,                    | Approximate                                    |
| ١,         | Physician  |                | shock, or heart failure. List on<br>Immediate Cause (Final   | ly one cause on each lir   | ie.                            |                      | -  | _                        |                              |                                   |                     | ~ d= -                   | _   ,                    | Interval Between<br>Onset and Death            |
|            | Physician<br>/Medical  |                | disease or condition<br>resulting in death)  | Due to (or as  | a consequence                  | of):                 | PUCTIVE  | pvc                      | MUN                          | ARY J                             | ) ()+               | -70=                     |                          | YFARI  |
|            | Examiner   |                | a second at a second and the   | b  | ,                              | .,                   |  |                          |                              |                                   |                     |                          |                          |  |
| l.         | ₽ #  | ner            | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | Due to (or as  | a consequence o                | of):                 |  |                          |                              |                                   |                     |                          |                          |  |
|            | ecute<br>and<br>trans  | Examiner       | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | C  |                                | - 6\.                |  |                          |                              |                                   |                     |                          | $\perp$                  |  |
| Ď,         | ficate be executed<br>physician and<br>is the burial-transit   |                | , and an additional and a second a second and  Due to (or as  | a consequence o                | or):                 |  |                          |                              |                                   |                     |                          |                          |  |
| 58/60,     |  | edical         |  | d  |                                |                      |  |                          |                              |                                   |                     |                          |                          |  |
| XOD        |  | n/Me           | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome   | pf pregnancy                   | _                    |  |                          |                              |                                   |                     | 23d. Date                | e of delive              | rv   |
|            | death cert<br>e attendin<br>ed for use a   | sician/M       | in the past 12 months?<br>1 ☐ Yes 2 ☑ No   | 4☐Pregnant at  | 2 Fetal death<br>time of death |                      | Ectopic pregnancy<br>Other (specify)                         | ′                        |                              |                                   |                     | Mor                      |                          | Day Year                                       |
| j.         | requires that the<br>een signed by the<br>rould be detache   | Phys           | 9 ☐ Unknown  | 9∐Unknown  |                                |                      |  |                          |                              |                                   |                     |                          |                          |  |
| ,<br>S     | es the   | by F           | Part II. Other significant conditions  |  |                                | _                    | derlying cause give  | en in Part               | l.                           |                                   |                     |                          |                          | e cause of death?                              |
| coras,     | requir<br>een s<br>nould   |                |  |  | NAGE                           |                      |  |                          |                              | 1,52                              | Yes 2               | 2 No                     | 3 ☐ Prob                 | ably 4 □Unknown                                |
| ပ္ပ        | e law<br>has b   | Completed      | HIPPRIENS  | 1 ~~   |                                |                      |  |                          |                              | 24a. Was<br>auto                  | psy                 | 24b. V                   | Vere autor               | osy findings available<br>npletion of cause of |
|            | i: The licate har, page  | Ço             |  |  |                                |                      |  |                          |                              | perfo<br>1∐ Yes                   | ormed?<br>2.24N     | 0 1                      | leath?                   | 2□ No  |
| VItal      | siciar<br>certif   | Be             | 25. Was case referred to medical examiner?   | Hospital:  |                                |                      | 2C DOA Otho  |                          |                              | (Check only o                     |                     |                          |                          |  |
| 0          | y Physer this eral di  | i: To          | 1 ☐ Yes 2 ☑ No 27. Manner of Death   | 28a. Date of Inju  | nt 2 ER/Out                    | tpatient<br>Fime of  | 3 DOA 28c. Injur   | 4 L N                    |                              | ne 5 Resi<br>8d. Describe         |                     |                          |                          | /)   |
| DIVISION   | nding<br>tth.<br>r: Afte<br>e fune   | Certification: | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigat   | (Month, Day  | Year) II                       | njury                |  | ƙ?<br>Yes 2[             |                              |                                   |                     | .,                       |                          |  |
| <u> </u>   | Atte   | ifica          | 3 ☐ Suicide 6 ☐ Could not<br>4 ☐ Homicide determine  |  | ury - At home, fai             | rm, stre             | et, factory, office  |                          | 2                            | 8f. Location (                    | Street a            | and Numbe                | er or Rura               | Route Number,                                  |
| 5          | Ital or<br>rrs afte<br>ral Di  | Cert           |  | Danis, or  | , (opeany)                     |                      |  |                          |                              |                                   | mi, oldi            |                          |                          |  |
|            | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | edical         | 29a. Certifier 1 Certifying (Check only one) 2 Medical Ex  | Physician: To the best<br>aminer: On the basis o<br>and manner sta | examination an                 | e, death<br>d/or inv | occurred at the tir<br>estigation, in my o                   | ne, date a<br>pinion, de | and place, a<br>eath occurre | and due to the<br>ed at the time, | cause(<br>, date ar | s) and ma<br>nd place, a | nner as st<br>and due to | ated.<br>the cause(s)                          |
|            | To the within To the comp  | Me             | 29b. Signature and title of certifier  | -/ N   |                                |                      | 29c. Licens  | e number                 | ,                            |                                   | 29d. D              | ate signed               | (Month, I                | Day, Year)                                     |
| 1          |  |                | Chalt.   | -Heisel  | m.)                            |                      | D2   | 635                      | 8                            |                                   | M                   | 441                      | 14.2                     | 1008   |
| . 0        | 1) 1   |                | 30. Name and address of person wh  | o completed cause of d   | eath (Item 23a) (              | Type, F              | Print)   |                          | 0                            |                                   |                     |                          | _                        | /  |
| 14         | r T  | 10             | 31. Date filed (Month, Day, Year)  | WEIGE 32. Registra   | Signature                      | - f                  | RIVEE  | +1                       | C F-3                        | -X (C                             | K                   | N                        | 2) 2                     | 20678  |
|            | Sta<br>Registr   |                | MAY  | 32. Registr.   | Delive .                       | K                    | Snorth &   | 10                       |                              |                                   |                     |                          |                          |  |
| DH         | MH 17 Rev 1/2  | 001            |  |  | ALENOOT I                      | ~                    | The said of  |                          |                              |                                   |                     |                          |                          |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month M9520 1155 a SUCIE 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Street Anna Anna Churchton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2 💢 F Months Days Hours Min 54 247-96-6025 7/9/1953 SC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No MD Anne Arundel Churchton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5512 Calvert Street <u> 21733</u> USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No
If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 X Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Title Company 12 Settlement Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Roscoe Parker</u> <u>Edwina Hotchkiss</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kim Hill/Daughter</u> 5945 Deale Beach Road, Deale, MD 20751 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Chesapeake Crem. 5/13/08 Beltsville, MD 21. Signature of Funeral Service L censee 22. Name and Address of Facility Raymond-Wood Funeral Home . a

**Physician** /Medical **Examiner** 

physician

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar months.

ed by the a

within 24 hours after death
To the Funeral Director:
completely filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

this After

|   |   | T  | 0 BOX 430, Dull  | KILK, MD  | 20734                    |                                 |
|---|---|--|--|---|--------------------------|---------------------------------|
|   | 23a. Part1. Enter the disease, or com<br>shock, or heart failure. List only | nplications that caused the death. Do not en one cause on each line.   | iter the mode of dying, such as cardian  | c or respiratory arrest,                                |                          | Approximate<br>Interval Between |
|   | Immediate Cause (Final disease or condition                                 | Breast   | unce   |   |                          | Onset and Death                 |
|   | resulting in death)   | Due to (or as a consequence of):   |  |   |                          |                                 |
| _                                       | Sequentially list conditions, if any, leading to immediate                  | b. Due to (or as a consequence of):  |  |   |                          |                                 |
| ŭ<br>L                                  | cause. Enter Underlying   | Due to (or as a consequence or).   |  |   |                          |                                 |
| xar                                     | that initiated events resulting in death) Last                              | c<br>Due to (or as a consequence of):  |  |   |                          |                                 |
| g                                       |   | . d  |  |   |                          |                                 |
| ledit                                   |   | EU   |  |   |                          |                                 |
| 2                                       | IF FEMALE:<br>23b. Was decedent pregnant                                    | 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 3[  | 75   |   | 23d. Date of de          | livery                          |
| completed by Physician/Medical Examiner | in the past 12 months?<br>1 ☐ Yes 2,A No<br>9 ☐ Unknown                     |  | _lEctopic pregnancy<br>☐ Other (specify)   |   | Month                    | Day Year                        |
| y<br>Z                                  | Part II. Other significant conditions of                                    | contributing to death but not resulting in the u   | inderlying cause given in Part I.  | 23e. Did tobacc   | o use contribute to      | the cause of death?             |
| Ω<br>Da                                 |   |  |  | 1 ☐ Yes   | 2 <b>№</b> 3 □ Pi        | robably 4 Unknown               |
| plet                                    |   |  |  | 24a. Was an   | 24b. Were a              | utopsy findings available       |
| E 0                                     |   |  |  | autopsy<br>performed<br>1□ Yes 2                        | death?                   | completion of cause of          |
| e<br>C                                  | 25. Was case referred to medical examiner?                                  | Hospital:  |  | ath (Check only one)                                    |                          |                                 |
| 0                                       | 1 Yes 2 No  | 1 Inpatient 2 ER/Outpatie  |  | lome 5 Residence  |                          | ecify)                          |
| ation:                                  | 27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation       |  | of 28c. Injury at Work?  M 1 Yes 2 No  | 28d. Describe how in                                    | jury occurred            |                                 |
| erillic                                 | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined                     |  | reet, factory, office  | 28f. Location (Street<br>City or Town, Sta              | and Number or Ri<br>ate) | ural Route Number,              |
| medical Certification:                  | 29a. Certifier 1 Certifying Ph<br>(Check only one) 2 Medical Exar           | ysician: To the best of my knowledge, deat<br>miner: On the basis of examination and/or ir<br>end manner stated. | th occurred at the time, date and place<br>ovestigation, in my opinion, death occu | I.e., and due to the cause<br>urred at the time, date a | (s) and manner as        | s stated.<br>e to the cause(s)  |
| Me                                      | 29b. Signature and tile of certifier  |  | 29c. License number  | 29d. [  | Date signed (Mont        | th, Day, Year)                  |
|   |   | <i>N</i>   | D00643   | 79  | 5/12/2                   | 300                             |
|   | 30. Name and address of person who  | completed cause of death (Item 23a) (Type,   | Print) - R2 Sute 300 A   | CM Word   | 31401                    |                                 |
| е                                       | 31. Date filed (Month, Day, Year)   | 32. Registrant Signature   | a R2 Sute 700 A  | 1   | 0-1 /0.                  |                                 |
| r                                       | MAY 1   | 3 2008 Breves &  | Sparke   |   |                          |                                 |
|   |   |  |  |   |                          |                                 |

State

Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** May 2008 2:45 Elva Pearl Tasker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakland Nursing & Rehab Center 0akland Garrett If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🗓 F Maryland April 12 1900 Director 108 219-34-6154 Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notified at 1 ☐ Yes 2 XNo Director MD Garrett Swanton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. r than "natural", or items 23a or the Medical Examiner must be United States 1976 Walnut Bottom Road 21561 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ≥ 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of the and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice Tichinel ၉ George Bray 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. 104 East Third Ave., Mtn. Lake Park, MD 21550 Carolyn Warnick, P.O.A. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5/17/08 Swanton, MD Turner Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home, P.A work 710 Church St., Kitzmiller, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Arterioscleratic Qav) corman /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dise to (or as a consequence of) Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? Day Year 4 □ Pregnant at time of death 5 Other (specify) 9 I Inknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Vasa 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate ha performed' 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 drsing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 □ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours aft ie Funeral Di iletely filled in 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 F 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Benes Drive Oakland, MD 7/100 Do 69 Wolf Miller Daniel 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 5 Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day **Physician** 8 2008 1:30 A.M May Junior Tingler /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Oakland Nursing & Rehab Center Garrett 0akland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 234-32-4325 West Virginia Director 80 6/23/1927 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show a or 28a-f show be notified at 1 ☐ Yes 2 🙀 No Director WV Randolph Whitmer 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ural", or Items 23a o Il Examiner must be United States 26296 Whites Run Road by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? I □ Yes 2 🔀 No f Yes. Give 1 ☐ Never Married 2 ☐ Married "natural", or 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Secondary (0-12) College (1-4or 5+) Canaan Valley Resort permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If item 27 is marked other th any injury or other traumatic event, the once. Laborer 12 should be filed what and Mental Hygier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tingler **Ethel** Marie E1za 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 133, Whitmer, WV 26296 Geraldine Day, Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify) Laurel Hill Cemetery 5/12/2008 Whitmer, WV 22. Name and Address of Facility
David A. Burdock Funeral Home, P.A. 21. Signature of Funeral Service Licenses Duritur 21 N. Second St., Oakland, MD 21550 Katherne 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 years VON HODEKINS Lymptoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and burial-tra Due to (or as a consequence of): Box 68760, attending physician for use as the buria certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No P.0. 9 Unknown signed by 1 I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No has autopsy performed 2**K** No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2X No Other: 4₺ Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28d. Describe how injury occurred I or Attending Fafter death. 1 🖪 Natural 5 Pending investigation 1 Yes 2 No neral Director; / 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours at To the Funeral C Hospital 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29c. License number 29b. Signature and title of certifier 30. Name and address of pers on who completed cause of death (Item 23a) (Type, Print) DaKland m D 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 1 2 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month 0.5 Susan Wigfield Ellen 0672008 8:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Garrett County Memorial Hospital 0akland Garrett If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 1 F 220-52-9689 Director Maryland 92 01/23/1916 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits r 28a-f show notified at show 1XYes 2□No Director 0akland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or minortant; if item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examiner must be 100e. USA 21550 1019 Madison Street Funeral death 1 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 2 🔼 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 XWidowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Owner/Operator Mote1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Hines Nina Gross 2 Amos 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Richie /Son 1907 Fingerboard Rd. Oakland, Maryland 21550 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrett Co. Memorial Gar. 5/10/08 Oakland, Maryland 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licens 32 South Second Street, Oakland, Maryland 21550 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Vill /Medical Due to (or as a consequence of): **Examiner** DYUNDYY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1□ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After t Attending Injury 5 Pending investigation To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of cortifier, 29d. Date signed (Month, Day, Year) H0026154 30. Name and address of person who complete ause of death (Item 23a) (Type, Print) Paul Daniel Miller, 69 Wolf Acres Dr., Oakland, MD 21550 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 8 2008 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

|                | - 64   |                | 1 - For State of Maryla   |                                   | artment of Health and M<br>rtificate of Death   |   | iene<br>eg. No. <b>200</b>                 | 8 17328   |
|----------------|--|----------------|---|-----------------------------------|---|---|--|---|
| ľ              | Physic   | ian            | 1. Decedent's Name (First, Middle, Last)  |                                   |   | Date of Death     Month                 |  | 3. Time of Death                                    |
| 4              | /Medi  | cal            | Baby Girl Banks   |                                   |   | May 19                                  |  | 21:40 M   |
|                | Exami  | ner            | 4a. Facility Name (If not institution, give street and number)  |                                   | 4b. City, Town, or Location of Death  | 4                                       | 4c. County of De                           | eath  |
|                | Funeral  |                | Greater Baltimore Medical Cen  5. Social Security Number 6. Sex 7. Age (In yrs  |                                   | TOWSON If Under 1 Year   If Under 24 Hrs.   | 8. Date of Birth                        | Baltimor                                   |   |
| Ŀ              | Director   |                | N/A 1□M 2∰F   | Yrs.                              | Months Days Hours Min. 50   | (Month, Day, 5/19/20                    | Year)                                      | Birthplace (State or Foreign Country)               |
|                | pu ,   |                | Usual Residence of Decedent   |                                   |   | 3/13/2.0                                | 100  | MD  |
|                | shov<br>shov   | 7              |   | ty, Town or Lo                    |   |   |  | 10d. Inside City Limits                             |
|                | the M<br>28a-f<br>notifie  | Director       | MD Baltimore Wi   | ndsor M                           |   |   |  | 1 Yes 2 No  |
|                | with<br>sa or<br>t be r  |                |   |                                   | 10f. Zip Code   | 10                                      | g. Citizen of What (                       | Country?  |
|                | death<br>ms 2;<br>mus  | Funeral        | 7500 Haystack Drive 11. Marital Status 12. Was Decedent Ever in U   | J.S. 13. \                        | 21244 Vas Decedent of Hispanic Origin? (Spe   | cify Yes or No.                         | USA<br>14. Bace - An                       | nerican Indian,                                     |
| 21215-0036     | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland<br>Department of Health and Mental Hygiene.<br>Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show<br>any injury or other traumatic event, the Medical Examiner must be notified at<br>once.  | by             | 1 ☑ Never Married 2 Married 1 ☐ Yes 2 ☑ No  |                                   | Vas Decedent of Hispanic Origin? (Spe<br>f Yes, specify Cuban, Mexican, Puerio f<br>☐ Yes 2☑ No Specify:  | Rican, etc.)                            | Black, Wh                                  | nite, etc.  |
| 5-0            | 72 ho<br>natur<br>lical  | Completed      | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Deced                        | ent's Usual Occupation  | , 1                                     | 6b. Kind of Busines                        | SIack<br>ss/Industry                                |
| 2              | nthin<br>ne.<br>han "  | å e            | Elementary/Secondary (0-12) College (1-4or 5+)  | life. L                           | kind of work done during most of workin<br>OO NOT use retired)  | ng                                      |  |   |
|                | iled w<br>Hygier<br>her ti   |                | O O O   |                                   | Infant  |   | <u> Infant</u>                             |   |
| and            | t be f<br>intal F<br>ed of   | Be             | ,   |                                   | 18. Mother's Name   | (First, Middle, M                       | laiden Surname)                            |   |
| Maryland       | should<br>nd Me<br>mark<br>matic   | ို             | Unknown  19a. Informant's Name/Relationship (Type. Print)   | 10h Mailin                        | Chanell g Address (Street and Number or Rural   | 1.D                                     | <u>Bank</u>                                |   |
|                | nd 2 galth ar  |                | GBMC PATHOLOGY  | (. Zo                             | Address (Street and Number of Hura)   | Tows                                    | City or Town, State                        | , Zip Code)   |
| ře,            | s 1 a<br>of Hea<br>item<br>othe  |                | 20a. Method of Disposition 20b.   | Place of Dispos                   | sition (Name of Department of |   | Oc. Location - City of                     | or Town, State                                      |
| Ë              | Page<br>nent c<br>nt: If   |                |   |                                   | witcher place)  | Jones V                                 | 30/18 CX                                   | TY.M.   |
| Baltimore,     | permit. Departn Importa any inju   |                | 21. Signature of Fune al Service Licensee   | <sup>22</sup> 7                   | Name and Address of Facility  | Son's C                                 | 0.   |   |
|                |  |                | 23a. Part1. Enter the disease, or complications that caused the deal shock, or heart failure. List only one cause on each line.   | h. Do not ente                    | r the mode of dying, such as cardiac or   | respiratory arres                       | st.  | Approximate   |
|                | Physician  |                | Immediate Cause (Final  |                                   |   | ,                                       | - ,  | Interval Between<br>Onset and Death                 |
|                | /Medical   |                | resulting in death)  a. Extendition  Due to (or as a consequence)   |                                   | Y   |   |  |   |
| H              | Examiner   |                | Sequentially list conditions b.   |                                   |   |   |  |   |
|                | p .tt  | iner           | Sequentially list conditions, if any, leading to immediate cause. Enter limit ryling.   | uence of);                        |   |   |  |   |
|                | and<br>I-trans   | Examiner       | Cause (Disease or Injury that initiated events resulting in death) Last   |                                   |   |   |  |   |
| 8760,          | cate be executed<br>physician and<br>the burial-transit  |                | Due to (or as a conseq  | uence oi):                        |   |   |  |   |
| 687            | ficate be executed<br>graphysician and<br>is the burial-transit  | edical         | d   |                                   |   |   |  |   |
| C. Box         | that the death certificed by the attending of the detached for use as  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. If yes, outcome pf pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of december 1 □ Unknown | Ideath 3□                         | Ectopic pregnancy<br>Other (specify)  |   | 23d. Date of de<br>Month                   | elivery<br>Day Year                                 |
| J.             | that<br>ned by<br>deta   |                | Part II. Other significant conditions contributing to death but not res   | ulting in the und                 | derlying cause given in Part I.   | 23e, Did toba                           | cco use contribute                         | to the cause of death?                              |
| ords           | The law requires that the te has been signed by the lage 2 should be detache   | eted by        |   |                                   |   |   |  | Probably 4 ☐Unknown                                 |
| Vital Records, |  | Completed      |   |                                   |   | 24a. Was an autopsy performe            | ed? prior to death?                        | autopsy findings available completion of cause of s |
| <u> </u>       |  | Be             | 25. Was case referred to medical examiner?  |                                   | 26. Place of Death  |   |  |   |
| Ö              | Physer this eral di  | 유              | 1 ☐ Yes 2 ☑ No Hospital: 1X ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury   | ER/Outpatient<br>28b. Time of     | I Training Holli  |   | ce 6 □Other (Spe                           | ecify)  |
| 0              | al or Attending F<br>s after death.<br>Il Director: After<br>d in by the funer   | Certification: | 1 ☑XIatural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation  | Injury                            | 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No  | 3d. Describe how                        | injury occurred                            |   |
| UIVISION       | Atternation of the part of the | itics          | 3 Suicide 6 Could not be 4 Homicide determined building, etc. (Specific   | me, farm, stree                   |   | Bf. Location (Stre                      | et and Number or F                         | Rural Route Number,                                 |
| 5              | tal or<br>s afte<br>al Dir<br>ed in  | Serr           | building, etc. (Specing   | ′)                                |   | City or Town,                           | State)                                     |   |
|                |  | Medical        | 29a. Certifier (Check only one)  1  Certifying Physician: To the best of my kno 2  Medical Examiner: On the basis of examina and manner stated.   | wledge, death<br>tion and/or inve | occurred at the time, date and place, are sstigation, in my opinion, death occurred   | nd due to the cau<br>d at the time, dat | use(s) and manner a<br>e and place, and du | is stated.<br>the to the cause(s)                   |
|                | To the Committee of the | Σ              | 29b. Signature and title of certifier   |                                   | 29c. License number   | 290                                     | d. Date signed (Mon                        | th, Day, Year)                                      |
| )              |  |                | 1 the   |                                   | D43003  | E.                                      | 5/21/2008                                  |   |
| $\wedge$       | 7  |                | 30. Name and address of person who completed cause of death (Item   | 23a) (Type, P                     |   |   | <del>1/21/2</del> 008                      |   |
| U              | -01-   |                | Nathan A. Dunsmore, M.D., 6701  31. Date filed (Month, Day, Year)  32. Registrar's Signal   | N. Cha                            | rles St., Baltimon  | re, MD 2                                | 21204                                      |   |
|                | Stat<br>Registra   |                | 31. Date filed (Month, Day, Year)  MAY 2 9 2008  39 Registrar's Signa   | Spe                               | W   |   |  | _   |
|                |  |                | 111111 20 20  |                                   |   |   |  |   |

|   |  |                  | 1 - For State Registrar  |   | •                               | epartment of l<br>Certificate of   |                                |  | Reg. No. 2 (          | 800   | 17329  |
|---|--|------------------|--|---|---------------------------------|--|--------------------------------|--|-----------------------|---|--|
|   | Physici  | an               | Decedent's Name (First, Middle, L.)  | Joseph L.   | Banks                           |  |                                | 2. Date of Dea<br>Month<br>May           | atn<br>Day<br>25, 200 | Year  | 3. Time of Death 4:00 P M                          |
|   | /Medio   |                  | 4a. Facility Name (If not institution, g<br>Gilchrist Center   | ive street and number)  | Damo                            | 4b. City, Town, o  | or Location of Death           | ridy 2                                   | 4c. Coun              | ty of Death                                   | e County   |
|   | Funeral<br>Director  |                  | 217-26-3000  | Sex 7. Age  | e (In yrs. last birthd<br>7 Yrs | (ay) If Under 1 Year   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birt<br>(Month, Da<br>Nov. 14 | th<br>v Year)         | 9. Birthp                                     | place (State or Foreign                            |
|   | Maryland<br>I-f show   | tor              | Usual Residence of Decedent  10a. State 10b. County  Maryland E  | Baltimore   | 10c. City, Town or              | r Location   | Edger                          | mere                                     |                       | 1   | 1 ☐ Yes 2 🎖 No                                     |
|   | 3a or 28a  | Funeral Director | 10e. Street and Number<br>7807 North Cove  | Road  |                                 | 10f. Zip Code 212  | 19                             |  | 10g. Citizen o        |   |  |
| 9500                                      | illed within 72 hours after death with the Maryland<br>Hygiene.<br>Wher than "natural", or items 23a or 28a-f show<br>ant, the predictal Examination political and | þ                | 11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced   | 12. Was Decedent E<br>Armed Forces?<br>15. Syes 2 1 N<br>If Yes, Give<br>Year or Dates: | Korean                          | I3. Was Decedent of leading to the | Specify:                       | ecify Yes or No<br>Rican, etc.)          | Spec                  | W   | etc.<br>hite                                       |
| 9500-6171                                 | be filed within 72 ho<br>tral Hygiene.<br>d other than "natur<br>event, the Medical  | Completed        | 15. Decedent's E<br>(Specify only highest g  | Education<br>rade completed)<br>College (1-4or 5  | +) (G                           | ecedent's Usual Occu<br>live kind of work done<br>le. DO NOT use retire  | during most of work<br>d)      | ing                                      | 16b. Kind of          |   | •  |
| yland 2                                   | eve eve  | Be               | 12 Years 17. Father's Name (First, Middle, Las   | t)  | I                               | Electricia   | 18. Mother's Name              | (First, Middle,<br>Elizabe               | Maiden Surna          |   | ustry  |
| מ   | d z snould<br>Ith and Me<br>?7 is mark<br>traumatic  | 2                | Joseph Banks  19a. Informant's Name/Relationship  Mrs. Dolores Bar   |   |                                 | ailing Address (Street   | t and Number or Rur            | al Route Numbe                           | er, City or Tow       | n, State, Zip                                 |  |
|   | perfini. Fages 1 and 2 should<br>Department of Health and Mer<br>Important: If Item 27 is marke<br>any injury or other traumatic<br>once.                          |                  | 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Cther (Spec   | ☐ Removal from State  | 20b. Place of Di                | sposition (Name of crematory or other pla  |                                | Date 0/2008                              | 20c. Location         | •   | own, State , Maryland                              |
| Baltimor                                  | Departm<br>Departm<br>Importar<br>any inju   |                  | 21. Signature of Funeral Service Lice  |   | 2                               | 22. Name and Addre<br>Duda-Ruc.  |                                | Home of                                  | f Dunda               | lk, I   | nc.  |
|   | hysician<br>/Medical<br>xaminer  |                  | 23a. Part 1. Enter the disease, or or shock, or he waiture. It is only immediate Cause (Final disease or condition resulting in death)               | a. MCTASTA  |                                 |  | ng, such as cardiac            | or respiratory ar                        | rrest,                |   | Approximate<br>Interval Between<br>Onset and Death |
| dor do,                                   | so be executed sician and so burial-transit  | ical Examiner    | Sequentially list conditions, if any back to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c   | a consequence of):              |  |                                |  |                       |   |  |
| DIVISION OF VICE DECOMES, F.O. DOX 60/60, | certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit   | Physician/Medi   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | 23c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown                            | 2 🗌 Fetal death                 | 3 ☐ Ectopic pregnand<br>5 ☐ Other (specify) _  | су                             |  |                       | ate of delive                                 | ery<br>Day Year                                    |
| COLOS, F.                                 | signed by  | þ                | Part II. Other significant conditions  | contributing to death bu  | t not resulting in the          | e underlying cause giv   | ven in Part I.                 | 23e. Did to                              | S.                    |   | he cause of death?                                 |
|   | te has beer<br>age 2 shou  | Completed        |  |   |                                 |  |                                | 24a. Was autop                           |                       | were auto<br>prior to co<br>death?<br>1 ☐ Yes | opsy findings available impletion of cause of      |
| 10  | h.<br>After this certificate h:<br>funeral director, page  | Be C             | 25. Was case referred to medical examiner?   |   |                                 |  | 26. Place of Deat              | 1  | /                     | 1 🗆 163                                       | 2 🗆 140  |
| 5 6                                       | this c   | မှ               | 1 ☐ Yes 2 ☐ No<br>27. Manner of Death  | Hospital:<br>1 ☐ Inpatie  | nt 2 ER/Outpa                   | tient 3 🗆 DOA  | ner: 4 Nursing Ho              | me 5 Resid                               |                       |   | n horpice  |
| I VISIOII                                 | within 24 hours after death.  To the Funeral Director: After completely filled in by the funeral process.  | Certification:   | 1 Natural 5 Pending 2 Accident investigation 3 Sulcide 6 Could not I 4 Homicide determined   | (Month, Day   | (Year) Injur                    | y Wor  | k?<br>]Yes 2□No                |  | Street and Nun        |   | al Route Number,                                   |
| Hoenital                                  | within 24 hours after Completely filled in by  | Medical Ce       |  | hysician: To the best of miner: On the basis of   | examination and/o               |  |                                |  |                       |   |  |
| Totho                                     | within to the comple   | Mec              | 29b. Signature and title of certifier  | and manner sta  | led.                            | 29c. Licens  | se number                      |  | 29d. Date sign        | ed (Month,                                    |  |
| 10  | )+   |                  | 30. Name and address of person who   | completed cause of de   | ath (Item 23a) (Typ             | pe, Print)  Nonico S   | of town                        | onno                                     | 212                   | 01  |  |
|   | Sta  | to               | 31. Date filed (Mpath Day Year))   | 2. Registra   | r's Signeture                   | 0  |                                |  |                       | 7   |  |

DHMH 17 Rev 1/2001

Registrar

| Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legi |
|---|
| State of Maryland / Department of Health and Mental Hygiene             |

|          |  |                | 1 - For State Of N<br>Registrar   | iaryiano i                        |                             | trificate of I                           | leaith and ivi<br>Death                     |                                  | giene<br>Reg. No 2                | <b>a</b> 8                | 17330  |  |  |
|----------|--|----------------|---|-----------------------------------|-----------------------------|--|---|----------------------------------|-----------------------------------|---------------------------|--|--|--|
| 2        | Physici  | an             | Decedent's Name (First, Middle, Last)   |                                   |                             |  |   | 2. Date of Dea<br>Month          |                                   | Year                      | 3. Time of Death                               |  |  |
| *        | /Medic   | al -           | VERONICA L. BOWMAN  |                                   |                             | 45 O'b T                                 | Landing of Dageth                           | MAY                              | 26, 2<br>4c. County               | 2008                      | 6:35P M  |  |  |
| )        | Examin   | er             | 4a. Facility Name (If not institution, give street and number CASEY HOUSE   | )                                 |                             | ROCKV                                    | Location of Death                           |                                  | Í                                 | GOME                      | οV   |  |  |
|          | Funeral  |                | 5. Social Security Number 6. Sex 7. A   | ige (In yrs. last                 | t birthday)                 | If Under 1 Year                          | If Under 24 Hrs.                            | 8. Date of Birtl<br>(Month, Day  | 1                                 |                           | lace (State or Foreign                         |  |  |
|          | Director   | 0              | 577 74 6650 1□MXX F   | 53                                | Yrs.                        | Months Days                              |   | JAN. 29, 1955 WASHINGTON, DC     |                                   |                           |  |  |  |
|          | and and  |                | Usual Residence of Decedent  10a. State 10b. County   | 10c. City, T                      | Town or Lo                  | cation                                   |   |                                  |                                   | 1                         | 0d. Inside City Limits                         |  |  |
|          | Maryl<br>f sho   | tor            | MD MONTGOMERY   | STIV                              | ER SI                       | DD T N/C                                 |   |                                  |                                   |                           | XXYes 2 □ No                                   |  |  |
|          | death with the Maryland<br>ms 23a or 28a-f show<br>r must be notifiled at  | Director       | 10e. Street and Number  | DITTA                             | EK DI                       | 10f. Zip Code                            |   |                                  | 10g. Citizen of                   | What Coun                 | try?   |  |  |
|          | 23a c<br>ust be  |                | 36 DUNSINANE COURT  |                                   |                             |  | 906   |                                  | UNITEI                            |                           |  |  |  |
|          | tems   | Funeral        | 11. Marital Status 12. Was Deceder Armed Forces   | ?                                 | 13. V                       | Was Decedent of H<br>f Yes, specify Cuba | ispanic Origin? (Spe<br>in, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.) | 14. Rad<br>Blad                   | ce - Americ<br>ck, White, |  |  |  |
| 36       | be filed within 72 hours after death with the Marylar ital Hygiene.<br>Ital Hygiene.<br>Id other than "natural", or Items 23a or 28a-f show<br>event, the Medical Examiner must be notified at   | by F           | 1 ☐ Never Married XXX Married 1 ☐ Yes XX<br>If Yes, Give<br>3 ☐ Widowed 4 ☐ Divorced Year or Dates                                | :<br>【NO                          | 1                           | i⊡Yes <b>X</b> XNo                       | Specify:                                    |                                  | Specif                            | v: BLAC                   | CK   |  |  |
| 5-0036   | 2 hou<br>latura<br>ical E  |                | 15. Decedent's Education<br>(Specify only highest grade completed)  | 1                                 | 16a. Deced                  | lent's Usual Occup                       | ation                                       |                                  | 16b. Kind of B                    | usiness/Inc               | dustry   |  |  |
| 7        | within 72<br>ene.<br>than "nai<br>he Medic   | Completed      | Elementary/Secondary (0-12) College (1-4o   | 5+)                               |                             |  | during most of worki<br>)                   | ng                               |                                   |                           |  |  |  |
|          | filed w<br>Hygier<br>other the   | Co             | 3YRS.   |                                   | PAF                         | RALEGAL                                  | 18. Mother's Name                           | /First Middle                    |                                   |                           | AW FIRM  |  |  |
| and      | d be feather the control of contr | ) Be           | ELMER BOWMAN  | T BROWN                           |                             | ie)                                      |   |                                  |                                   |                           |  |  |  |
| $\leq$   | should<br>and Men<br>marke   | L<br>L         | 19a. Informant's Name/Relationship (Type. Print)  |                                   | 19b. Mailin                 | g Address (Street                        | and Number or Rura                          |                                  |                                   | State, Zip                | Code)  |  |  |
| , Ma     | s 1 and 2 sh<br>of Health and<br>item 27 Is m<br>other traum   |                | DEREK RUCKER / HUSBAND  |                                   |                             | JNSINANE                                 |   | SILVER                           | SPRING                            | MD 2                      | 20906  |  |  |
| ore,     | iges 1<br>it of He<br>If item<br>or oth  |                | 20a. Method of Disposition 1 ☐ Buria! XX Cremation 3 ☐ Removal from State   | 20b. Place                        | e of Dispon<br>netery, cren | sition (Name of<br>natory or other plac  | :e)   | Date                             | 20c. Location                     | City or To                | wn, State                                      |  |  |
| Baitimor | tment of tant: If it   |                | 4 ☐ Donation 5 ☐ Other (Specify)  |                                   |                             |  | ATORY 5/2                                   |                                  | ALEXA                             |                           |  |  |  |
| ga       | permit. Pac<br>Departmen<br>important:<br>any Injury once.   |                | 21. Signature of Funeral Service Licensee ONALD R.  | GRAY                              | MA<br>Δ3                    | Name and Address ARSHALL'S BOS SUITL     | FUNERAL                                     | HOME OF                          | MARYLA                            | ND, J                     | INC.   |  |  |
| у.       |  |                | 23a. Paint. Enter the disease, or complications that caus<br>shock, or heart failure. List only one cause on each                 | ed the death. [                   |                             |  |   |                                  |                                   | _207                      | Approximate<br>Interval Between                |  |  |
| 1        | Physician  | Î              | Immediate Cause (Final disease or condition METAS'  |                                   | REASI                       | CANCER                                   |   |                                  |                                   | 1                         | Onset and Death                                |  |  |
| ′        | /Medical<br>Examiner   |                | resulting in death)  Due to (or a   | s a consequen                     | nce of):                    |  |   |                                  |                                   |                           |  |  |  |
|          |  | e              | Sequentially list conditions, if any, leading to immediate b. Due to (or a  | s a consequen                     | nce of):                    |  |   |                                  |                                   | -                         |  |  |  |
| 18       | uted<br>d<br>ansit   | Examine        | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events |                                   |                             |  |   |                                  |                                   |                           |  |  |  |
| ,<br>J   | tificate be executed<br>g physician and<br>as the burial-transit   |                |   | s a consequen                     | nce of):                    |  |   |                                  |                                   |                           |  |  |  |
| 8/60,    | ate be<br>hysici<br>the bu   | edical         | d   |                                   |                             |  |   |                                  |                                   |                           |  |  |  |
|          | certific<br>nding p  |                | IF FEMALE: 23c. If yes, outcom  | e of pregnanci                    | v                           |  |   |                                  | 001 0                             | 1                         |  |  |  |
| g<br>Q   | atter<br>for u   | Physician/M    | in the past 12 months?  | 2 ☐ Fetal de<br>at time of deat   | eath 3                      | Ectopic pregnancy Other (specify)        |   |                                  |                                   | ite of delive<br>onth     | Day Year                                       |  |  |
| Ç        | t the c<br>by the<br>achec   | hysi           | 9 ☐ Unknown 9 ☐ Unknown   |                                   |                             |  |   |                                  |                                   |                           |  |  |  |
| S,       | ician: The law requires that the de certificate has been signed by the ector, page 2 should be detached  | by P           | Part II. Other significant conditions contributing to death   | but not resultin                  | ng in the ur                | nderlying cause give                     | en in Part I.                               |                                  |                                   |                           | ne cause of death?                             |  |  |
| cords    | equir<br>sen si<br>rould b   |                |   |                                   |                             |  |   | 1 D Y                            | ′es X2X No                        | 3 ☐ Prob                  | ably 4 Unknown                                 |  |  |
| ec<br>C  | has b  | Completed      |   |                                   |                             |  |   | 24a. Was a<br>autop              | sy                                | prior to cor              | psy findings available<br>mpletion of cause of |  |  |
|          | n: The licate har, page  |                |   |                                   |                             |  |   | 1□ Yes                           | 2121                              | death?<br>1 ☐ Yes         | 2 No   |  |  |
| >        | Physician:<br>this certific<br>ral director,   | o Be           | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ ☒ o Hospital: 1 ☐ Inpa  | tient 2□ER                        | l/Ωutnatien                 | t 3DDOA Oth                              | er:   |                                  |                                   |                           | HOSPICE  |  |  |
| 10       |  | n: To          | 27. Manner of Death 28a. Date of In   | jury 28                           | Bb. Time of<br>Injury       |  |   | 28d. Describe h                  |                                   |                           | // HOSTICE                                     |  |  |
| SION     | Attending r death. sctor: After on the fune  | atio           | 2 Accident investigation  | Lly Your,                         | ,,                          |  | Yes 2 □ No                                  |                                  |                                   |                           |  |  |  |
|          | The fee  | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of i building,   | njury - At home<br>etc. (Specify) | e, farm, stre               | eet, factory, office                     |   | 28f. Location (S<br>City or Tow  | itreet and Numl<br>n, State)      | er or Rura                | l Route Number,                                |  |  |
|          | To the Hospital within 24 hours at To the Funeral Completely filled  | edical C       | 29a. Certifier (Check phi) one)  XX Certifying Physician: To the besicant one)  Medical Examiner: On the basic and mediner:       | of examination                    | edge, death<br>n and/or in  | occurred at the tirvestigation, in my    | ne, date and place,<br>pinion, death occur  | and due to the red at the time,  | cause(s) and m<br>date and place, | anner as si               | tated.<br>the cause(s)                         |  |  |
|          | To the Hos<br>within 24 hd<br>To the Fun<br>completely   | Mec            | 29b. Signature and title of certifier   |                                   |                             | 29c. License                             | e number                                    |                                  | 29d. Date signe                   | ed (Month,                | Day, Year)                                     |  |  |
| )        |  |                | Bensere No Ob   | earlos                            |                             | D64                                      | 615   |                                  | MAY 27                            | , 200                     | 08   |  |  |
|          | 11   |                | 30. Name and address of person who completed cause of   | death (Item 23                    |                             |  |   |                                  |                                   | -                         |  |  |  |
|          | Sta  | to             | GENEVIEVE WROBLEWSKI, M.D. 31. Date filed (Month, Day, Year) 32. Regis  | trar's Signature                  |                             | 1 MUNCAS                                 | TER MILL                                    | RD. R                            | OCKVILL                           | E, MI                     | 20850  |  |  |
|          | Registr  |                | MAY 2 0 2008  |                                   | 1                           | 1.                                       |   |                                  |                                   |                           |  |  |  |

ORIGINAL

State Registrar 31. Date filed (Month, Day, Year)

2 9 2008

DHMH 17 Rev 1/2001

SUITE 610, GLEN BURNIE, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RAIN

32. Registrar's Sig

HWY

Division or Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: filled in by the fi To the Funeral I within 24

> State Registrar

DHMH 17 Rev 1/2001

Medical

Signature and title

29a. Certifie

pmpleted cause of death (Item DEFENSE A GHWAY ANNAPOLIS M N 21401 J. LARENTAM 32. Registrar's Signature

tated

and manny

ORIGINAL

20a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 20:32 Hazel Lorraine Berryman May 20, 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Joppatowne
If Under 1 Year | If Under 24 Hrs Harford 594 Renee Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Min. Hours Months 1 M 2 F 213-36-0225 82 Dec. 24, Director 1925 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Harford Joppatowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 594 Renee Drive 21085 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify. Completed by Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Nurse and Mental Hygi injury or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I Edna Aline Nash Robert Henry Berryman ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 27 Linda Rowell Pages 1 and / Niece P.O. Box 5095, Nikolaevsk, AK 99556 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) 4 ☐ Donation Cedar Hill Cemetery 5-31-08 Baltimore, Maryland of Fundral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed HB8 Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 ☐Unknown 1 🗌 Yes Then CANCER 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed ALCOHOLISM this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

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State

Registrar

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31. Date filed (Month, Day,

0

Year)

2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

D31093 Nancy Prosser

27, 2008 Box 68760. P.O.

physician and the burial-trans

certificate has

After this

the Hospital or Attending

Baltimore, Maryland 21215-0036

Division or Vital Records, BEACHAM

6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within 24 hours after death

To the Funeral Director: completely filled in by the f Medical

29b. Signature and title of certifier Posts J. Man, MD 29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 ROBERT MOSS, M.D. 31. Date filed (Month, Day, Year)

Registrar



State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year May 25, 2008 Physician 12:15 Charles Beattie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Unit D Baltimore 104 Cross Keys Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth (Month, Bay, Year) 1/6/1940 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Kentücky 407-50-4151 XXM 2□ F 68 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show unt; or Items 23a or 28a-f show uny or other traumatic event, Ita Maydic, Exc. infort mut be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 No Baltimore Director MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21210 Unit D 104 Cross Keys Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married > Married Baltimore, Maryland 21215-0036 1 ∐Yes 2XXNo Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physician Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rowena Sanders Alexander T. Beattie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 104 Cross Keys Road Unit D Baltimore, MD 21210 Melissa C. Beattie / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition
1 ☐ Burial 2 ★ remation 3 ☐ Removal from State permit. Pages 1
Department of H
Important: If Ite
any injury or ot Hilltop Serv. Corp. 5/27/08 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TOWSON, MD 21. Signature of Funeral Service Licensee Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MINUHE resulting in death) /Medical Due to (or as a con equence of): **Examiner** MMXMISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Due to (or as a consequence of): Box 68760, 38 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No P.O. should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 DINo 1 ☐Yes 2 ☐ No Division of Vital completely filled in by the funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 29c. License number cause of death (Item 23a) (Type, Print) 30. Name and address of person wh 40000 32. Registrar's 31. Date filed (Month, Day, Year) State MAY 29 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month May 21 1:30 PM Margaret Elizabeth Bayne 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Multi Medical Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day, Year) 4/23/1925 9. Birthplace (State or Foreign Maryland 1 □ M 2 🛛 F Months Days Hours Min. 83 213-20-4490 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Towson 1 ☐ Yes 2 ◯ **(**No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 32 Dunvale Road apt 203 21204 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes ※ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3x Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bank Teller Finance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Martin H. Phipps Edna Rutledge 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 Walter E. Bayne, III / Son 205 E. Joppa Road unit 605 Towson, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 → Burial 2 □ Cremation 3 □ Removal from State Dulaney Valley 5/24/2008 Timonium, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility TOWSON, MD 21204 21. Signature of Funeral Service Licenses Ruck Towson Funeral Home, Inc. 1050 York lelisse 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE moneti Due to (or as a consequence of): CEREBRO VASCULAR DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 morths? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) I∐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐Yes ₽ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1□Yes 3☑No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mapmer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **√** Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

**Physician** /Medical Examiner certificate be executed

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or ite may injury or other traumatic event, Its Medical Examinan and.

Director

Funeral

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Completed

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21215-0036

Baltimore, Maryland

Box 68760,

P.O.

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Division of Vital

sician and burial-transit attending physician for use as the buria Physician/Medical detached for signed by \$ Completed has certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. Be ည Certification:

10

Medical

SHAKUNMACA 31. Date filed (Month, Day, Year) State Registrar

29a. Certifier (Check only one)

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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MAY 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** <sup>□</sup>¶8 2008 220 AM Edward J. Baker May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Ritchie Hospice N/A Baltimroe Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Y 4 / 4 / 4 6 **Funeral** 218-42-7735 1**X**M 2□F Months Days Hours Min. 62 **Director** NC Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ıral", or items 23a or 28a-f shov Examiner must be notified at MD N/A Baltimore Y Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 101 S. Morey Street USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. African filed within 72 hours after Hygiene. 1 ☐ Yes 2 ☐ You If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" American permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any Injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Steel Laborer 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rodell Baker Evelyn McDonald ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrona Baker/Daughter 173 Shetland Circle, Reistertown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 □ Surial 2 □ Cremation 3 □ Removal from State 5/27/08 Balt./,MD Mt. Carmel Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitari P. Close F.S. P.A. 5126 Belair Rd, Balt., MD 21206-5105 21. Signature of Fund al Septice License 23a. Part1. Enter the disease, or complications that caused the death. Do not ever the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician NCUT disease or condition resulting in death) /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s autopsy performed: certificate 2 **X**No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this ( 2 funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the Funeral Director: npletely filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State)

4 Homicide

determined

LIS

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2008

29a. Certifier

(Check only one)

Medical

State

Registrar

31. Date filed (Month, Day, Year) MAY 29 2018 3 Registrar's Signature

MD

Baltimore, Maryland 21215-0036

requires that the death certificate be executed

P.O. Box 68760,

Division or Vital Records,

the Hospital or Attending

hours after

within 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 2008 5:00 arrington seph 101 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical eterans Center B21 Bal Timur If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Hours 68 Director 220-36-4231 12/01/1939 Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 XYes 2 No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1735 Braddish Avenue 21216 U.S.A. 12. Was Decedent Ever in U.S.
Armed Forces?
1A Yes 2 □ No 1958
If Yes, Give
Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status American Indian. Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 No ş Specify. Specify: Black 3 ☐ Widowed 4 ▼ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Security Guard 12 Prison 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lesley Carrington Pearl Boxley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy White / Daughter 403 Greentree Circle, Abingdon, Maryland 21009
ce of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/03/2008 Owings Mills, Maryland Garrison Forest Ceme. 21. Signature of Funeral Service Licensee The Derrick C. Jones F/H, P.A. 4611 Park Hots. Ave. Baltimore, Maryland 21215
sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Retrieval 23a. Part1. Enter the disease, or complications that has shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Metastatic ancreatic Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy performe 1☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🗂 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manur of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician the as nse for signed by the a has been page certificate

or Attending Physician:

within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

ral", or items 23a or 28a-f show Examiner must be notified at

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other than

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permit. Pages 1 and 2 sh
Department of Health and
Important: If item 27 Is m
any injury or other traum

**Physician** 

**Examiner** 

and

burial-transit

/Medical

or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Battimore,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Crevere E. Wicks IN MD, 3900 Loch Roven Boulevard 31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

State Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death

4b. City, Town, or Location of Death BALTIMORE 1903 h

4c. County of Death

N/A

| Physician |
|-----------|
| /Medical  |
| Examiner  |

For State Registrar

Leona

MINIA

J.

4a. Facility Name (If not institution, give street and number)

Cardona

HOSPITAL

Director "natural", or items 23a or 28a-f shov adical Examinar must be notified at than,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oththe any injury or other traumatic event once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed attending physician and for use as the burial-tran page certificate l or Attending Physician: director. After this funeral death. after death e Funeral

Division of Vital Records, P.O. Box 68760

If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) SEP 7 1958 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex Funeral 1 □ M 2 X F Months Days Min 142-56-7399 New Jersey Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yes 2 No Director Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 304 Highland Drive, Apt. T1 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married δ 1 □Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Cashier P arking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cardona Jean Pecarsky Joseph G. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Hohenberger – friend 304 Highland Drive, Apt. T1, Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/21/2008 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Williams <sup>22</sup>Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to for as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( as a consequence of) Exami Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 🗆 No 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 D Mo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 ☐ Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Snow Cater 5

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

within 2

Registrar's Signature

|                            |  |                | 1 - For<br>State<br>Registrar  | State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2008 173 |  |   |   |  |   |   |  |  |
|----------------------------|--|----------------|--|--|--|---|---|--|---|---|--|--|
|                            | Physic   |                | Decedent's Name (First, Middle, Last,  Mary  |  | /  | III O O   |   | 2. Date of Dea                             | Death Span Span Span Span Span Span Span Span |   |  |  |
| *                          | /Medi<br>Examir  |                | 4a. Facility Name (If not institution, give  | · · · · · · · · · · · · · · · · · · ·  |  | 4b. City, Town, or Baltimore                                      |   | 1 1 1                                      | 4c. County of De                              |   |  |  |
|                            | Funeral<br>Director  |                | 5. Social Security Number 6. Se 215-52-2580  | <u> </u>   | ge (In yrs. last birthday)<br>58 Yrs.  | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs<br>Hours Min.                     | . (Month, Day,                             | Year) 9. B                                    | irthplace (State or Foreign<br>ountry)<br>aryland                               |  |  |
|                            | Maryland<br>a-f show<br>fied at  | ctor           | Usual Residence of Decedent  | more   | 10c. City, Town or Lo  |   | sex   |  |   | 10d. Inside Cify Limits 1 ☐ Yes 2🛣 No   |  |  |
|                            | ath with the Mari<br>23a or 28a-f sl<br>ust be notified  | al Director    | 10e. Street and Number  3 Russell Frost  | Court  |  | 10f. Zip-Code   | 21221   | 1  | Og. Citizen of What C                         | •   |  |  |
| 980                        | d within 72 hours after death with the Maryland<br>giene.<br>In than "natural", or items 23a or 28a-f show<br>the Medical Examiner must be notified at                     | by Funeral     | 11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced  | 12. Was Decedent<br>Armed Forces?<br>1  Yes 2 If Yes, Give<br>Year or Dates:                         | -No  | Nas Decedent of His<br>f Yes, specify Cubar<br>I □ Yes 2 및 No     | spanic Origin? (S<br>n, Mexican, Puer<br>Specify: | Specify Yes or No-<br>to Rican, etc.)      | 14. Race - Am<br>Black, Wh<br>Specify:        |   |  |  |
| 1215-0036                  | within 72 ho<br>iene.<br>than "natura<br>he Medicai E  | Completed      | 15. Decedent's Edu<br>(Specify only highest grad   |  | (Give<br>life. L   | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired) | uring most of wo                                  | orking                                     | 16b. Kind of Busines                          | s/Industry  |  |  |
| Maryland 21                | be file<br>ntal Hy<br>od othe<br>event,  | To Be Co       | 12 Years  17. Father's Name (First, Middle, Last)  Donald M. Wi  | they   | 1  | Housewife   |   | ame (First, Middle,                        |   | 2   |  |  |
|                            | d 2 she  |                | 19a. Informant's Name/Relationship (Ty<br>Mr. Paul R. Cuda   | oe. <i>Print)</i><br>(Husban   | 1  |   |   |  | x, City or Town, State,                       | ,   |  |  |
| Baltimore,                 | S = 5  |                | 20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)   | 1 /  | 111  | Cemeter   | y 5/3   | Date<br>31/2008                            | 20c. Location - City o                        | r Town, State   |  |  |
| Ball                       | permit. Page<br>Department of<br>important: If<br>any injury or<br>once.   |                | 21. Sign ture of the rail Service Licenses   | pr.  |  | 7922 Wise   | Funeral   | undalk, I                                  | Dundalk,<br>Maryland                          | 21222   |  |  |
| -                          | Physician<br>/Medical  |                | shock, or heart failure. List only or<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)   | e cause on each lir<br>a. Acu te   | a consequence fi:  | atory   | Dishe   | C  | -crome  | Approximate<br>Interval Between<br>Syset and Death                              |  |  |
| 19                         | cate be executed  physician and the burial-transit   | dical Examiner | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as  | a consequence of):  Consequence of):   | theur Ader  | no car  | unon                                       | <u>na</u>                                     | Days  |  |  |
| P.O. Box 68                | The law requires that the death certifica te has been signed by the attending phoage 2 should be detached for use as the   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown  | 3c. if yes, outcome 1  Live birth 4  Pregnant at 9  Unknown  | 2 Fetal death 3  | Ectopic pregnancy Other (specify)                                 |   |  | 23d. Date of d<br>Month                       | elivery<br>Day Year   |  |  |
| rds, P.                    | quires that the signed by all the details  | þ              | Part II. Other significant conditions con  | ntributing to death b  | out not resulting in the u   | nderlying cause giv   | en in Part I.                                     | 23e. Did tol                               |   | to the cause of death? Probably 4 Dunknown                                      |  |  |
| al Reco                    |  | Completed      |  |  |  |   |   | 24a. Was ar<br>autops<br>perform<br>1  Yes | prior to<br>med? prior to<br>death?           | autopsy findings available completion of cause of s 2 \( \subseteq \text{No} \) |  |  |
| Division of Vital Records, | To the Hospital or Attending Physician: The within 24 hours after death.  Of the Funeral Director, After this certificate completely filled in by the funeral director, pa | ation: To Be   | 25. Was case referred to medical examiner?  1   Yes   2   No    27. Manner of Death 1   Natural   5   Pending investigation  | lospital: 1 Impatie<br>28a. Date of Inju<br>(Month, Day  | ry 28b. Time of  | 28c. Injury<br>Work?  | r: 4 □ Nursing H                                  |  | ence 6 Other (Special Other)                  | ecify)  |  |  |
| Divis                      | Hospital or Attending<br>24 hours after death.<br>Funeral Director: After<br>stely filled in by the fune   | Certification: | 3 ☐ Suicide 6 ☐ Could not be determined  | building, etc  |  |   |   | City or Town                               |   |   |  |  |
|                            | To the Hospital within 24 hours To the Funeral completely filled   | edical         | one) 2 Medical Exami   | iclan: To the best oner: On the basis of and manner sta  | of my knowledge, death<br>f examination and/or invated.  | estigation, in my op  | inion, death occ                                  | urred at the time, o                       | date and place, and d                         | ue to the cause(s)  |  |  |
|                            | 0 1 kg 0   | Σ              | 29b. Signature and title of certifier  |  | MD   |   | 0556  | 1  | 9d. Date signed (Mon                          | th, Day, Year)  |  |  |
|                            | //)<br>Sta   | te.            | 30. Name and address of person who could be seen and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person and address of person address of person address of person and address of person a | Llov   | death (Item 23a) (Type, Item 23a) (Type, | Print)  | 600   | North Wol                                  | 6.0   | ore, MD, 21287  |  |  |
|                            | Registr  | ı.e            | MAY 2 9 2008   | Algaria.   | K Brast  | 2   |   |  |   |   |  |  |

|          |   |                | For   | State of M                                  | laryland                   |                                 |                                  |                                   |                            |                                 |                            |                           |  |
|----------|---|----------------|---|---|----------------------------|---------------------------------|----------------------------------|-----------------------------------|----------------------------|---------------------------------|----------------------------|---------------------------|--|
|          |   |                | 1 - State<br>Registrar  |   |                            | Cert                            | tificate d                       | of Death                          |                            |                                 | Reg. No. 2                 | 008                       | 17341  |
|          | Physicia  | an             | Decedent's Name (First, Middle, Language)   | ,   |                            |                                 |                                  |                                   |                            | Month                           | ath Day                    | Year                      | 3. Time of Seatiff                                 |
| 12.      | /Medic  |                | Carol Virginia  4a. Facility Name (If not institution, gi   |   | )                          |                                 | 4h City Tou                      | n, or Location                    |                            | nky                             | 126 21<br>40 COUR          | ty of Death               | 6 33A.M.   |
| Ĭ        | Examin  | er             | 0 11  |   | :0-1 (                     | anlan                           | Glen                             | Run                               | or Death                   | ,                               | Ann                        |                           | rundal   |
|          | Funeral   |                |   | Sex 7. A                                    | ge (in yrs. la             | ast birthday)                   | If Under 1 Y                     |                                   |                            | 8. Date of Birt                 | h                          | 9. Birth                  | place (State or Foreign                            |
|          | Director  |                | 217-32-8381   | 1 □ M 2 🔀 F                                 | 73                         | Yrs.                            | Months Da                        | ys Hours                          | Min.                       | (Month, Da<br>Dec. 18           |                            | Mary                      | vland  |
|          | and w   |                | Usual Residence of Decedent  10a, State 10b, County   |   | 10c. City                  | , Town or Loc                   | ation                            |                                   |                            |                                 |                            |                           | 10d. Inside City Limits                            |
|          | f sho   | or             |   |   |                            |                                 |                                  |                                   |                            |                                 |                            |                           | 1 □ Yes 🎗 🔀 No                                     |
|          | the 1   | Director       | Maryland Anne A   | Arundel                                     | GT6                        | en Burr                         | 10f. Zip Co                      | le                                |                            |                                 | 10g. Citizen o             | f What Cou                | ntry?  |
|          | h with  |                | 102 Marley Sta  | ation Road                                  |                            |                                 |                                  | 21060                             |                            |                                 | United                     | l Stat                    | es   |
|          | ems :   | Funeral        | 11. Marital Status  | 12. Was Deceden<br>Armed Forces             | t Ever in U.S              | 3. 13. W                        | as Decedent<br>Yes, specify      | of Hispanic Or<br>Cuban, Mexica   | rigin? (Spe                | cify Yes or No-<br>Rican, etc.) | - 14. R                    | ace - Ameri               |  |
| 2        | s afte  | by Fu          | 1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 😿                                 |                            |                                 | □Yes 2√2                         |                                   |                            |                                 | Spec                       |                           | nite   |
| ۶        | hour tural  |                | 15. Decedent's E  | Year or Dates:                              |                            | 16a. Decede                     | ent's Usual O                    | cupation                          |                            |                                 | 16b. Kind of               | Business/Ir               | ndustry  |
| 2        | in 72<br>in "na<br>Medic  | plet           | (Specify only highest gi  | rade completed) College (1-4or              | 5+)                        | (Give k<br>life. D              | ind of work do<br>O NOT use re   | one during mos<br>tired)          | st of workin               | ng                              |                            |                           | ,  |
| 7        | d with  | Completed      | 10  | Conege (1-40)                               |                            | Home                            | emaker                           |                                   |                            |                                 |                            | Own                       | Home   |
| 2        | be file<br>tal Hy<br>d othe   | Be (           | 17. Father's Name (First, Middle, Las   | ,   |                            |                                 |                                  |                                   |                            | (First, Middle,                 |                            | ame)                      |  |
| 7        | 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at   | ٩              | Irwin Maxwell F   |   |                            |                                 |                                  |                                   |                            | ll Gar                          |                            |                           |  |
| 2        | d 2 sh<br>th and<br>7 Is n<br>traun   |                | 19a. Informant's Name/Relationship John T. Coady / I  |   |                            | 1                               |                                  |                                   |                            | <i>Route Numb</i><br>d Glen     |                            |                           |  |
| ָט<br>ע  | s 1 and 2 should be filed within 72 hours after death with the Marylar if Health and Mental Hygiene at the Res 23a or 28a-f show flem 21 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at |                | 20a. Method of Disposition  |   | 20b. Pl                    | ace of Dispos<br>emetery, crem  |                                  |                                   | May 3                      |                                 | 20c. Location              |                           |  |
| 2        | permit. Pages 1 and 2 Department of Health 8 Important: If Item 27 is any Injury or other tra   |                | 1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec   |   | <i>,</i>                   | emetery, crem<br>ar Hil]        |                                  |                                   | мау 3<br>2008              | · .                             | Brookly                    | n Par                     | rk. MD   |
| <u>=</u> | permit. Departm Importar any Inju   |                | 21. Signature uneral Service Lice   |   |                            |                                 |                                  | ·                                 | ity<br>k Euro              |                                 |                            |                           | •  |
| ٥        | De L. C   | 1              | 1 Jan Leto  | aux   |                            | 42                              | zi^cFăi                          | n Hwy.                            | s.E.                       | eral H                          | Burnie,                    | MD 2                      | 21061  |
|          |   |                | 23a. Part1. Enter the disease, or cor shock, or heart failure. List only                            | npli ations that cause<br>y n cause on each | ed the death<br>line.      | . Do not ente                   | r the mode of                    | dying, such as                    | s cardiac o                | r respiratory a                 | rrest,                     |                           | Approximate<br>Interval Between<br>Onset and Death |
|          | Physician   |                | Immediate Cause (Final disease or condition resulting in death)                                     | a Sest                                      | cen                        | mA                              | 0                                |                                   |                            |                                 |                            |                           | Onset and Death                                    |
| •        | /Medical<br>Examiner  |                | resulting in death)   | Due to Pr                                   | s a conse                  | enc. of):                       | + .                              | N. 1.                             |                            | 1                               | ^                          |                           |  |
|          |   | er             | Sequentially list conditions,   | b. Due to (or a                             | s a consequ                | ence of);                       | me_                              | +mm                               | my                         | us.                             | ease                       | -                         |  |
| ١.       | d<br>d<br>ansit   | Examiner       | il any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | Conga                                       | enr                        | e he                            | ent t                            | arlesse                           | `                          |                                 |                            |                           |  |
| ב<br>ב   | e exec<br>an an<br>irial-tr   |                | resulting in death) Last  | Due to (or a                                |                            | ence of):                       | -                                | 0'                                |                            |                                 |                            |                           |  |
|          | The law requires that the death certificate be executed attentions in the last the nast the burial-transit gage 2 should be detached for use as the burial-transit  | dical          |   | d   | nan                        |                                 | ten .                            | mee                               | when                       |                                 |                            |                           |  |
| 5<br>≺   | death certific<br>attending p   |                | IF FEMALE:  | 23c. If yes, outcom                         | o of progna                | 1                               | 1                                |                                   |                            |                                 |                            |                           |  |
| 2        | eath c<br>attend<br>for us  | sian,          | 23b. Was decedent pregnant<br>in the past 12 months?<br>1□Yes 2√2 No                                | 1 ☐ Live birth                              | 2 ☐ Fetal                  | death 3□I                       | Ectopic pregn<br>Other (specif   |                                   |                            |                                 |                            | Date of deliv<br>Month    | very<br>Day Year                                   |
| į        | the d   | Physician/Me   | 1 ☐ Yes 2 V ☐ No<br>9 ☐ Unknown   | 9□Unknown                                   | at time of de              | ,aan 0 <u>0</u>                 | Olifor (Special                  | /                                 |                            |                                 |                            |                           |  |
| ١,       | luires that the de<br>signed by the a<br>ld be detached f   | by Pr          | Part II. Other significant conditions   | contributing to death                       | but not resu               | Iting in the und                | derlying cause                   | given in Part                     | I.                         | 23e. Did to                     | obacco use co              | ntribute to               | the cause of death?                                |
| Š        | v require   | ed b           |   |   |                            |                                 |                                  |                                   |                            | X                               | Yes 2□ No                  | 3 ☐ Pro                   | bably 4 Unknown                                    |
| 2        | e lav requ<br>has teen<br>je 2 should   | Completed      |   |   |                            |                                 |                                  |                                   |                            | 24a. Was                        |                            | . Were aut                | opsy findings available ompletion of cause of      |
|          | The page  | Com            |   |   |                            |                                 |                                  |                                   |                            |                                 | rmed?                      | death?<br>1 ☐ Yes         | 2 □ No   |
| A 110    | Iclan<br>Certific<br>ector  | Be             | 25. Was case referred to medical examiner?  | Hospital:                                   |                            |                                 |                                  |                                   | e of Death                 | (Check only o                   | nne)                       |                           |  |
| 5        | Phys<br>r this<br>ral dir   | . To           | 1 Yes 2 No 27. Manner of Death  | 28a. Date of In                             |                            | ER/Outpatient<br>28b. Time of   |                                  |                                   |                            | ne 5 Resident                   |                            |                           | ify)   |
| 5        | rding<br>th.<br>: Afte<br>s fune  | tion           | 1 Natural 5 Pending<br>2 Accident investigation   | (Month, D                                   |                            | Injury                          |                                  | Injury at<br>Work?<br>1 □ Yes 2 □ |                            |                                 | now injury coo             | 41104                     |  |
| 2        | Atter   | ifica          | 3 ☐ Suicide 6 ☐ Could not I determined  | 200. Flace Ul II                            | jury - At horetc. (Specify | me, farm, stre                  | et, factory, of                  | ice                               | 2                          | 8f. Location (S<br>City or Tox  | Street and Nur             | nber or Rui               | ral Route Number,                                  |
| 2        | tal or safte  | Certification: |   | Danang                                      | no. (opcom)                |                                 |                                  |                                   |                            | Ony or rov                      | m, state)                  |                           |  |
|          | the Hospital or Attending Physician: in 24 hours after death. the Funeral Director: After this certifical inpletely filled in by the funeral director.  | edical         | (Check only 2 Medical Exa   | hysician: To the bes<br>miner: On the basis | of examinat                | vledge, death<br>ion and/or inv | occurred at ti<br>estigation, in | ne time, date a<br>my opinion, de | nd place, a<br>ath occurre | and due to the ed at the time,  | cause(s) and date and plac | manner as :<br>e, and due | stated.<br>to the cause(s)                         |
|          | To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director. page   | Med            | one)  29b. Signature and title of pertifier   | and manner s                                | tated.                     |                                 | 29c. Lie                         | ense number                       |                            |                                 | 29d. Date sign             | ned (Month                | . Dav. Year)                                       |
|          | 7 with  | -              | ASTER   | T   | 11                         |                                 | N                                | 4297                              | 7                          |                                 | h/\a                       | 71-                       | 2008   |
|          | ا ر   | 1              | 30. Name and address of rson who  | completed cause of                          | death (Item                | 23a) (Type, P                   | rint)                            | 1011                              | -                          |                                 | i m                        | 10                        | . 200  |
|          | 5   |                | Complen Cheri   | mp. 301                                     | HOSA                       | in marin                        | 1 aire                           | Coler                             | 13                         | mme                             | - my                       | 1 2                       | 4061.  |
| 7        | Sta   |                | 31. Date filed (Month, Day, Year)   | 32. Regis                                   | rar's Signal               | re/                             |                                  | (                                 |                            |                                 |                            |                           |  |
|          | Registr   | ar             | MAY 2 9 2008  | Rugage                                      | H                          | Societies                       | ,                                |                                   |                            |                                 |                            |                           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2008 May Month 24, Thomas G. Cook 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Joseph Richey Hospice Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 216-28-3377 1**X** M 2 □ F Months Hours Min. 77 30,1931 Jan MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Director MD Middle River 1 ∐Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3206 Dahlia Lane 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 2 Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Tele-cr@dit 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Evin M. Cook မ Susan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stewart Bruette /step-son 3206 Dahlia Lane Baltimore MD 21220 20b. Place of Disposition (Name of Cemetery, crematory or other place)

Bayview Crematory 5/28/08 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Baltimore MD chix Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or Con lications that caused the shock, or heart failure. List only line cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final CANCER UNG ~ NON-SMALL WEEKS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Directo (or as a nonsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar autopsy performed 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manne of Death 1 Natura! 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Physician/Medical Completed Be

Certification: To

Medical

DougLAS 31. Date filed (Month, Day,

Year)

MAY 29

2008

Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

r than "natural", or items 23a or 28a-f shov tre Medical Exerticer must be notified at

filed within 72 hours after death with the Maryland

ould be filed within Mental Hygiene.

7 Is marked other traumatic event, I

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai

Physician

/Medical

Examiner

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Records, The law requires

Vital

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Division

Physician:

e Hospital or Attending P 24 hours after death. e Funeral Director: After t

24 hours a

within 24 ho

To the Fune

21215-0036

Baltimore, Maryland

DM

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GILLY CAMPERE, COLUMBIA MD 21045 SS 61 Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland Departmen 880 Health and Wiental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** Phipps Clark May 0332AM 2003 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Union Memorial Baltimore Date of Birth Day, Year, 2/2//1957 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (in yrs. last birthday) **Funeral** Hours Min. 1 XM 2 ☐ F Months Days Mary land 51 215-72-4628 Director Usual Residence of Decedent 10d. Inside City Limits 10h County 10c City Town or Location 10a. State show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, the "not of all Examiner must be notified at 1 ¥Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21218 USA 3120 St. Paul Street Unit 207 C Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify: SpecifyWhite 2 3 ☐ Widowed 4 🔀 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1,4or 5+) Senior Purchacier Purchaser Medical Supply 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Emory Clark Bessie Phipps 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any injury or other trau 404 Oak Pond Drive St. Johns, FL 32259 Stacey Cowen / Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/29/2008 Towson, Maryland Hilltop Serv. Corp. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Towson, MD 21204 1050 York Road Ruck Towson Funeral Home, Inc. Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Sepsis 8 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Circhosis Examiner Sequentially list conditions, if any, leading to immediate cause for the desired cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ne To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi Exami Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 □Yes 2 □ No 5 ☐ Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4, ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 2 □ No 1 □Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manper of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 124 hours after death.
 Euneral Director: A letely filled in by the formula 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of conffie AT 2438946HZ May 24, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital, MD Matthew ,D.O.

DHMH 17 Bev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Daniels 2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Hopkins Bayview Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 14,1913 9. Birthplace (State or Foreign Days Maryland 1 □ M 2X F 212-03-8761 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 🛣 No Dundalk maryland Baltimore 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number USA 21222 7603 Merritt Point Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 ◯XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Housewife 9 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Margaret Kinsey William Legg 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 515 Fountain Drive, Linthicum, MD. 21090 Great-Niece Michele Popp 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dundalk, Maryland Oak Lawn Cemetery June 3, 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License connelly funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease for complications that caused the death shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) espivator Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Year Month Day in the past 12 mon 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 No 24a. Was an autopsy perform 2 No 1∐ Yes

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

or 28a-f show notified at

ral", or items 23a or Examiner must be

'natural",

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Health and Mental em 27 is marked o

permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

Directo

Funeral

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Completed

or Attending Physician: The law requires that the death certificate be executed as the burial-tran the attending physician s after death. al Director: After the

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical Completed by Be Certification: To filled in by the funeral

| Part II. Otl | ner significant | conditions contrib | outing to death but | not resulting in the | underlying cause | given in Parl |
|--------------|-----------------|--------------------|---------------------|----------------------|------------------|---------------|
|              |                 |                    |                     |                      |                  |               |
|              |                 |                    |                     |                      |                  |               |

| 25. Was case referred to medical                                    | 26. Place of Death (Check only one)                    |   |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|
| examiner?<br>1 ☐ Yes 2 X No   | Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 I | Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)                                  |  |  |  |  |  |  |  |
| 27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigatio | 28a. Date of Injury 28b. Time of Injury at Work?       | 28d. Describe how injury occurred ☐ No  |  |  |  |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined              |  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State) |  |  |  |  |  |  |  |

29a. Certifier

★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

RE8-000

Baltimore, MD 2/224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

9

Eastern Avenue 32. Registrar's Signature

State Registrar

J 0

To the Hospital within 24 hours a To the Funeral C Hospital

Registrar
DHMH 17 Rev 1/2001

State

BALTIBURE,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signature

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2008

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31. Date filed (Month, Day, Year)

MAY 29

|               |                | State Registrar   |                            |                          |  | Cei                                 | rtifica                | ate of                      | Death                       |                            |  |                      | 200                       |   |
|---------------|----------------|---|----------------------------|--------------------------|--|-------------------------------------|------------------------|-----------------------------|-----------------------------|----------------------------|--|----------------------|---------------------------|---|
| sicia         | ın             | 1. Decedent's Name (First, Mid  | ,                          | · C                      |  |                                     |                        |                             |                             |                            | 2. Date of De<br>Month                 | ath<br> AYDay        | 26, 20                    | 3. Time of Death  |
| ledic<br>amin |                | Richard W.  4a. Facility Name (If not institution   |                            |                          |  | do                                  | 4b. Cit                | ty, Town, o                 | r Location                  | of Death                   | . 70                                   | 4c.                  | Countying D               | Pitimore  |
|               | er             | baint Jose  | pn m                       | earc                     | ar te  | nver                                |                        |                             | 1                           | OMPL                       | 111                                    |                      | , 10 et                   | I CIMOL.6   |
| eral          |                | 5. Social Security Number   | 6. Sex                     | 2□ F                     |  | s. last birthday)<br>Yrs.           | If Und<br>Month        | ler 1 Year<br>s Days        | If Under<br>Hours           | 24 Hrs.<br>Min.            | 8. Date of Bir<br>(Month, Da<br>01-04- | th<br>ay, Year)      | 9. 1                      | Birthplace (State or Foreign<br>Country)                |
| or            |                | 186-36-7446 Usual Residence of Decedent   |                            |                          | 63   | 115.                                |                        |                             |                             |                            | 01-04-                                 | 1945                 |                           | PA  |
|               |                | 10a. State 10b. Count   | у                          |                          | 10c. C   | City, Town or Lo                    | cation                 |                             |                             |                            |  |                      |                           | 10d. Inside City Limits                                 |
|               | Director       | PA Da   | uphin                      |                          |  | Humme1                              | stow                   | n                           |                             |                            |  |                      |                           | 1 X Yes 2 □ No  |
|               | Dire           | 10e. Street and Number  | C1 - C                     | N I                      |  |                                     | 10f. 2                 | Zip Code                    | 20                          |                            |  | 10g. Citi            | zen of What               |   |
|               | Funeral        | 640 S. Craw   |                            |                          | edent Ever in                                  | US 13 V                             | Was Dec                | 170                         |                             | igin? (Spe                 | cify Yes or No                         | )-                   |                           | .S.A.   |
|               |                | 1 Never Married 2 Ma  | rried                      | Armed Fo<br>1 ☐ Yes      | rces?<br>2 🔀 No                                |                                     |                        |                             |                             |                            | cify Yes or No<br>Rican, etc.)         |                      | Black, W                  |   |
|               | d b            | 3 Widowed 4 Divorce   |                            | If Yes, Gir<br>Year or D |  |                                     | 1 Ll Yes               | 2 <b>X</b> No               | Specify:                    |                            |  |                      | Specify:                  | White   |
| 1             | Completed      | 15. Decede<br>(Specify only high  | ent's Education            | on<br>ompleted)          |  | 16a. Dece                           | dent's Us              | vork done                   | ation<br>during mos<br>d)   | t of workin                | ng .                                   | 16b. Kii             | nd of Busine              | ss/Industry   |
|               | dmo            | Elementary/Secondary (0-12)   |                            | College (1               | I-4or 5+)                                      | ille. I                             |                        | pervi                       |                             |                            |  |                      | Macl                      | ninist  |
|               | BeC            | 17. Father's Name (First, Middle  | e, Last)                   |                          |  |                                     |                        | per vi                      |                             | er's Name                  | (First, Middle                         | , Maiden             |                           | 111130  |
|               | 일              | Russell   | Clark                      |                          |  |                                     |                        |                             |                             | May                        | Mardio                                 | ck                   |                           |   |
|               | 1              | 19a. Informant's Name/Relation  |                            | . ′                      |  |                                     | -                      |                             |                             |                            | l Route Numb                           |                      |                           | e, Zip Code)  |
| l             | Į.             | Corinne L. De 20a. Method of Disposition  | Rita /                     | Wit                      |  | Place of Dispo                      |                        |                             | ford                        |                            | Humme                                  |                      |                           | 17036<br>or Town, State                                 |
| l             |                | 1 X Burial 2 ☐ Cremation  |                            | oval from                | State  | cemetery, crem                      | natory o               | r other plac                |                             |                            | -2008                                  |                      | levill                    |   |
| ı             | 1              | 4 ☐ Donation 5 ☐ Other (  | -                          | 1                        | )  30  |                                     |                        |                             | ss of Facili                | hv                         |  |                      |                           |   |
| l             |                | 1 Barba   | 10 7                       | 4/11                     | 411  |                                     | 1050                   | York                        | Rd                          | Tow                        | Ruck Id<br>son, Mi                     | wson<br>21           | Funer<br>204              | ral Home, Inc   |
|               |                | 23a. Part 1. Enter the disease, shock, or heart failure. Lis  | or complicati              | ions that c              | aused the dea                                  | _                                   |                        |                             |                             |                            |  |                      |                           | Approximate<br>Interval Between                         |
| Ì             | 1              | Immediate Cause (Final disease or condition   | a                          | CAN                      |  |                                     |                        |                             |                             |                            |  |                      |                           | Onset and Death   |
| ı             |                | resulting in death)   |                            | Due to                   | or as a conse<br>FHOMA                         | quence of):                         |                        |                             |                             |                            |  |                      |                           |   |
|               | ē              | Sequentially list conditions, if any leading to immediate   | b                          |                          | or as a conse                                  |                                     |                        |                             |                             |                            |  |                      |                           | 1   |
|               | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events | <b>5</b>                   | SEP                      | SIS  | - 10-21                             |                        |                             |                             |                            |  |                      |                           |   |
|               | ὧ∣             | resulting in death) Last  | U                          | Due to                   | (or as a conse                                 | quence of):                         |                        |                             |                             |                            |  |                      |                           |   |
| l             | edical         |   | d                          |                          |  |                                     |                        |                             |                             |                            |  |                      |                           |   |
|               | Mec            | IF FEMALE:  | 230                        | If yes out               | come of preg                                   | nancy                               |                        |                             |                             |                            |  |                      |                           |   |
|               | Physician/M    | 23b. Was decedent pregnant in the past 12 months?   |                            | 1 Live I                 | birth 2 ☐ Fe                                   | tal death 3 🛭                       |                        | pregnanc<br>(specify) _     | 'y                          |                            |  | 2                    | 23d. Date of<br>Month     | Day Year  |
|               | hysi           | 1 ☐ Yes 2 ☐ No<br>9 ☐ Unknown   |                            | 9 Unkn                   |  |                                     |                        |                             |                             |                            |  |                      |                           |   |
|               | D<br>P         | Part II. Other significant condi  | tions contrib              | uting to de              | eath but not re                                | sulting in the ur                   | nderlying              | cause giv                   | en i <b>n</b> Part I        | •                          | 23e. Did 1                             | obacco u             | se contribute             | to the cause of death?                                  |
| l             | ted            |   |                            |                          |  | -·                                  |                        |                             |                             |                            | 1 🗆                                    | Yes 2[               | □ No 3□                   | Probably 4 Unknown                                      |
|               | Completed      |   |                            |                          |  |                                     |                        |                             |                             |                            | 24a. Was<br>auto                       | psy                  | prior                     | autopsy findings available<br>to completion of cause of |
|               |                |   |                            |                          |  |                                     |                        |                             |                             |                            | 1 □ Yes                                | 2 No                 | death<br>1 🗆 Y            | es 2 No   |
|               | Be             | 25. Was case referred to medic examiner?  1 ☐ Yes 2 No  | al<br>Hosp                 | oital:                   | Constitute of                                  | 750/0 1                             |                        | DOA Oth                     | Or:                         |                            | (Check only o                          |                      |                           |   |
|               | 음              | 27. Manner of Death   |                            | 28a. Date                | of Injury                                      | ER/Outpatier<br>28b. Time of        |                        | 28c. Injur<br>Worl          | 4 LI N                      |                            | ne 5 Resi                              |                      | · ·                       | pecify)   |
| l             | atio           | 1 Natural 5 Pend<br>2 Accident inves  | ing<br>tigation            | (Mon                     | th, Day, Year)                                 | Injury                              | М                      |                             | k?<br>Yes 2□                | No                         |  |                      |                           |   |
|               | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide deter   | not be<br>mined            | 28e. Place<br>buildi     | of Injury - At Ing, etc. (Spec                 | home, farm, stre                    | eet, facto             | ory, office                 |                             | 2                          | 8f. Location (<br>City or To           | Street and           | d Number or               | Rural Route Number,                                     |
|               |                |   |                            |                          |  |                                     |                        |                             |                             |                            |  |                      |                           |   |
|               | ledical        | 29a. Certifier 1 X Certify (Check only one) 2 Medica  | ing Physici<br>i Examiner: | : On the b               | best of my kr<br>asis of examir<br>ner stated. | nowledge, death<br>nation and/or in | n occurre<br>vestigati | ed at the ti<br>on, in my c | me, date ai<br>ppinion, dea | nd place, a<br>ath occurre | and due to the<br>ed at the time,      | cause(s)<br>date and | and manne<br>place, and o | r as stated.<br>due to the cause(s)                     |
|               | Mec            | 29b. Signature and title of certific  | er                         | and mail                 | stateu.  |                                     | 2                      | 9c. Licens                  | e number                    |                            |  | 29d. Dat             | e signed (Mo              | onth, Day, Year)  |
| - 1           |                | 7   |                            |                          | -0   | 2                                   |                        | DBØ                         | 263                         |                            |  |                      | 5-28                      | -08   |
|               |                | 6   |                            |                          |  |                                     |                        |                             |                             |                            | 1                                      |                      |                           | 0   |
|               | -              | 30. Name and address of perso   | n who compl                | leted caus               | e of death (Ite                                | em 23a) (Type,                      | Print)                 |                             |                             |                            | N. MAR                                 | -                    |                           |   |

08-04019

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Jasper Newton Ele  |                | 2nd<br>- For State                      | St                         | ate of               | Maryland                          | l / Depar<br><i>Cert</i> | rtment<br>tificate | of Hea                 | Ith and<br><i>th</i> | Menta                       | al Hygi                   |                              | g. No.           | 26                            | 108            | 1731   |
|--|----------------|---|----------------------------|----------------------|-----------------------------------|--------------------------|--------------------|------------------------|----------------------|-----------------------------|---------------------------|------------------------------|------------------|-------------------------------|----------------|--|
| Physiciar  |                | egistrar<br>I. Decedent's Name          | e (First, Midd             | e,Last)              |                                   |                          | modeo              |                        |                      |                             | 2.                        | Date of Death                | )                | Year                          | 3. Time        | e of Death                                     |
| Malical Examin   |                | Jasper                                  |                            |                      | ler, II                           |                          |                    |                        |                      | N.                          |                           | Month<br>May 26, 20          | 08               |                               |                | 30 hrs   |
| -  |                | 1a. Facility Name (i                    |                            |                      | treet and number                  | er)                      |                    |                        | Town, or lerstown    | Location of                 | Death                     |                              |                  | County of Dea                 | .h             | III T  |
|  |                | Route 40 ne                             |                            |                      |                                   | (la : ::a la             | at hieth day       |                        | der 1 Year           |                             | 24Hrs. 8                  | Date of Birth                | _                | DD/YYYY) 9. B                 | irthplace      | (State or                                      |
| Funeral  | -              | 5. Social Security N                    |                            | 6. Sex               |                                   | Age (In yrs. Ia          |                    | Mont                   |                      |                             | 1                         | Nov. 5                       |                  | Fore                          | ian            | Virginia                                       |
| Director   |                | 232-64-2                                |                            | 1_XM                 | 2_F                               | 66                       |                    | Yrs.                   |                      |                             | 1                         | NOV. 3                       | , 1.             | 741 1                         |                |  |
| ž.   |                | Usual Residence o<br>10a. State         | 10b. County                |                      |                                   | 10c. City,               | Town or Lo         | ocation                |                      |                             |                           |                              |                  |                               |                | nside City Limits                              |
| Chow a si  |                | WV                                      | Mario                      | n                    |                                   | Fair                     | rmont              |                        |                      |                             |                           |                              |                  |                               | 1              | Yes 2 X No                                     |
| sarylan at one   | Director       | 10e. Street and Nu                      | mber                       |                      |                                   |                          |                    | 10f. Z                 | ip Code              |                             |                           | 10                           | 0g. Citiz        | zen of What Co                | untry?         |  |
| the Man or 2   | [급             | 809 Mary                                | land A                     | venu                 | ıe                                |                          |                    |                        | 6554                 |                             |                           |                              |                  | S.A.                          |                |  |
| with ms 23   | era            | 11. Marital Status                      |                            |                      | 12. Was Decede                    |                          | S. 13.             | Was Dece               | dent of His          | spanic Origi<br>n, Mexican, | in? ( Speci<br>Puerto Ric | ify Yes or No-<br>can, etc.) | •                | 14. Race - Ame<br>White, etc. | erican Ind     | lian, Black,                                   |
| death<br>or ites   | Funeral        | 1 Never Marri                           |                            | 1                    | 1 Yes                             | 2 X No                   |                    |                        |                      | specify:                    |                           |                              | Ì                | Specify: Wh                   | ite            |  |
| s after<br>rral",<br>niner   | ক্র            | 3 Widowed  15. Decedent's E             |                            | 10                   | Yes, Give Yaar<br>or Dates:       | completed)               | 16a, Dece          | edent's Usua           | al Occupat           | tion (Give k                | ind of wor                | k done                       | 1                | Kind of Busines               |                | y  |
| 2 hour<br>"nate  | Completed      | Elementary/Sec                          |                            |                      | College (1-4                      |                          | durin              | ng most of w           | orking life          | e. DO NOT u                 | use retired               | 1)                           |                  |                               |                |  |
| 336<br>thin 7,<br>re.<br>than  | a<br>B         | 12                                      |                            |                      |                                   |                          | Qu                 | ality                  |                      |                             |                           |                              |                  | ack Tru                       | ck C           | ompany   |
| 5-00<br>ed wi<br>tygier<br>other   | ठ              | 17. Father's Name                       |                            |                      |                                   |                          |                    |                        |                      |                             |                           | irst, Middle, M<br>Rexrod    |                  | Surname)                      |                |  |
| 121<br>I be fil<br>ental I<br>arked  | å              | Jasper N                                |                            |                      | Deleta)                           |                          | Tage M             | niling Addre           | 255 /Street          |                             |                           |                              |                  | ity or Town, St               | ate, Zip C     | Code)  |
| Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | ]٩             | 19a. Informant's N                      |                            |                      |                                   | 2)                       |                    |                        |                      |                             |                           |                              |                  | 26554                         |                | ,  |
| and 2 and 2 cealth item 2 traum  | ł              | 20a. Method of Dis                      | sposition                  |                      |                                   | 20b.                     | Place of Di        | sposition (N           | lame of ce           |                             |                           | Date                         | 20c.             | Location - City               | or Town,       | State  |
| OFFE<br>ges 1<br>at of H<br>t: If i  |                | 1 X Burial 2                            |                            |                      | Removal from                      | State                    | -                  | or other plac<br>n Cem |                      | ,                           | Mav                       | 31, 08                       | F                | airmont                       | , WV           | r  |
| Itim<br>nit. Pa<br>artmer<br>ortan   |                | 4 Donation 5                            | Other Suneral Service      | Specify:<br>e Licens | ee //                             | 1 110                    | Jan                | 22. Name a             | nd Addres            |                             |                           | uneral                       | <u> </u>         |                               |                |  |
| Dep Dep Inju   |                | 2/0                                     | mis                        | 17                   | pter                              | ne                       |                    | 209                    | Merch                | nant S                      | St.                       | Fairmo                       | nt.              | WV 265                        | 54             | Secretary fortunated                           |
| Physician  |                | 23a. Part I. Enter t                    | the disease, only one caus | or compli            | cations that caus<br>h line.      | sed the death            | n. Do not er       | nter the mod           | de of dying          | , such as ca                | ardiac or r               | espiratory arr               | rest, sh         | nock, or heart                |                | proximate Interval<br>tween Onset and<br>Death |
| 'M dical   |                | Immediate Cause                         | (Final diseas              | e a.                 | Hypertens                         |                          |                    | erotic                 | cardio               | ovacci I                    | lar di                    | 99336                        |                  |                               | _              | Death  |
|  | l i            | or condition result                     |                            | b                    | ue to (or as a co                 | onsequence o             | Of):               |                        |                      |                             |                           |                              |                  |                               |                |  |
|  | ĕ              | Sequentially list of any, leading to it | immediate                  |                      | ue to (or es e n                  | risacuence c             | of):               |                        |                      |                             |                           |                              |                  |                               |                |  |
|  | Examine        | cause. Enter Und<br>(Disease or injury  | that initiated             | c                    | ue to (or as a c                  | onsequence (             | of):               |                        |                      |                             |                           |                              |                  |                               |                |  |
| uted<br>Id<br>ansit  | Ex             | events resulting in                     | n death) Las               | d                    |                                   |                          |                    |                        |                      |                             |                           |                              |                  |                               | $\perp$        |  |
| O,<br>e be executed<br>ysician and<br>burial - transit   | edical         | MUNPENDE                                | D                          |                      | AMENDED 23a,27,                   | marWF d                  | 880 6/             | 11/00 n                | יויו                 |                             |                           |                              |                  |                               |                |  |
| 760,<br>cate bo  | /Me            | IF FEMALE:<br>23b. Was deceder          | et pregnant in             | the                  | 23C. II yes, 00                   | icome or brei            | gnancy             | _                      | _                    | Estoni                      | c pregnan                 | NCV                          | 2                | 3d. Date of deli<br>Month     | very<br>Day    | Year   |
| 68° certificanting   | sician/M       | past 12 mont                            | ns?                        |                      | 1 Live birt                       | n<br>nt at time of d     | 2 L<br>leath 5     | Fetal dea              |                      |                             | o program                 | ,                            |                  |                               |                |  |
| Box 68760, e death certificate be the attending physic ed for use as the bur   | ysi            | 1 Yes 2                                 | No 9 L                     | Inknown              | 9 Unknow                          |                          |                    |                        |                      |                             |                           | T 00 - 5: 1                  |                  | 4-16-14                       | - to the a     | ours of death?                                 |
| ecords, P.O. Box 68760, he law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial - transi  | by Phy         | Part II. Other sig                      | nificant con               | ditions              | contributing to                   | leath but not            | resulting in       | the underly            | ying cause           | e given in Pa               | art I.                    |                              | es 2             | No 3                          |                | 4 V Unknown                                    |
| S, P<br>nires th   | a pa           | -                                       |                            |                      |                                   |                          |                    |                        |                      |                             |                           | 24a. Was                     |                  | 24b. Wer                      | e autopsy      | y findings available                           |
| ords<br>w requas been  | plet           |   |                            |                      |                                   |                          |                    |                        |                      |                             |                           | auto                         | opsy<br>formed   | prior                         | to compl       | letion of cause of                             |
| Rec<br>The la<br>cate h  | Completed      |   |                            |                      |                                   |                          |                    |                        |                      |                             |                           | 1 Yes                        | 2                | No 1 🗸                        | Yes            | 2 No   |
| tal F<br>tian:<br>certifi<br>ector,  | Be             | 25. Was case ref examiner?              | erred to medi              |                      | ospital:                          |                          | ED/Outs            | patient 3              | 26.Pla               | Other                       |                           | Home 5                       | Resi             | dence 6 🗸                     | <br>Other: Sce | ene  |
| f Vi<br>Physi<br>er this   | 2              | 1 Yes  27. Manner of De                 | 2 No                       |                      |                                   | patient 2                |                    | ne of Injury           |                      | njury at Wor                |                           |                              |                  | njury occurred                |                |  |
| on of the office | ion:           | 1 X Natural                             |                            | ending               | 28a. Date o<br>(Month,            | Day,Year)                |                    |                        | 1                    | Yes 2                       | No                        |                              |                  |                               |                |  |
| Division of Vital Records, P.O. ral or Attending Physician: The law requires that the ras after death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach   | Certification: | 2 Accident 3 Suicide                    |                            | vestigation          | 28e Place                         | of Injury - At           | home, farm         | n, street, fac         | ctory, office        | e building, e               | etc.                      | 28f. Location or Town,       |                  |                               | r Rural F      | Route Number, City                             |
| ital or after a filled in  | ertii          | 3 Suicide 4 Homicide                    | de                         | etermined            | (Specify)                         |                          |                    |                        |                      |                             |                           |                              |                  |                               |                |  |
| Division of Vital Records, P.O. Box 68766 To the Hospiral or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b   | alC            | 29a. Certifier 1                        | Certifying                 | Physici              | an: To the best<br>On the basis o | of my knowle             | edge, death        | occurred a             | t the time,          | date and p                  | lace, and                 | due to the ca                | use(s)<br>te and | and manner as                 | stated.        | use(s)   |
| Fo the<br>within<br>compl  | Medical        |   |                            |                      | and manner st                     | ted.                     | and/or inv         | estigation, i          |                      | nse numbe                   |                           |                              |                  | d. Date signed                |                |  |
|  | Σ              | 29b. Signature a                        | nd title of cer            | itter                | 200                               |                          |                    |                        |                      | C.M.E.                      |                           |                              |                  | lay 27, 2008                  |                |  |
|  |                | Tata                                    | LL                         |                      | 1966                              | of dooth /li-            | am 23a)            |                        |                      |                             | -                         |                              |                  |                               | 7.             |  |
|  |                | 30. Name and ac<br>Patricia A           |                            |                      |                                   | nt Medica                | l Examir           | ner 11                 | 1 Penn               | Street, B                   | Baltimor                  | e, MD 212                    | 201              |                               |                |  |
| S  | tate           | 31. Date filed (M                       | onth, Day, Ye              | ar)                  | 3 Re                              | gistrar's Signa          |                    | £ .                    |                      |                             |                           |                              |                  |                               |                |  |
| Regis  | tra            | 59                                      | 1AY 2 9                    | 200                  | 8 Mary                            | 483 1                    | 7                  |                        |                      |                             |                           |                              |                  |                               |                |  |
| DHMH 17 Rev 1/2  | 2001           |   |                            |                      |                                   |                          | ÖRIG               | GINAL                  |                      |                             |                           |                              |                  |                               |                |  |

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| 1   State   1      |                    |                                    | •        | For<br>State<br>Registrar                                  | State of Ma                                    | ryiaria /                    |             | ificate of L                          |  | F                                | Reg. No. 20       | 80             | 173  | 48                 |
|--|--------------------|------------------------------------|----------|--|--|------------------------------|-------------|---------------------------------------|--|----------------------------------|-------------------|----------------|--|--------------------|
| A TOTAL SAME PARTIES AND PARTI | ī                  | Physicia                           | an       | 1. Decedent's Name (First, Middle, Lasi                    | )  |                              |             |                                       |  |                                  | Day               | Year           | 3. Time of D                                 |                    |
| POWERLAND  TO SERVICE AND THE SECOND TO SERVICE AND THE SECOND TO SERVICE AND THE SECOND |                    | /Medic                             | al       |  |  |                              |             | 4h City Town or                       | Location of Death                          | May                              | 7 7               |                | JA.  | IVI                |
| 23 - 23 - 23 - 23 - 23 - 23 - 23 - 23 -  | A. C.              | Examin                             | er       | D:10. 11 1   | (0 c . D)                                      | ( = L                        |             | 12 e                                  | 1 Air                                      | ,                                | 1/                | _              |  |                    |
| 237—388—7586   100 Country   100 Cotty   1 |                    | Funeral                            | -        | 5. Social Security Number 6. Se                            | x 7. Age                                       |                              |             |                                       |  | 8. Date of Birt                  | h                 | 9. Birthplac   | ce (State or I                               | -oreign            |
| 100. Closes      |                    |                                    |          | 237-38-7586  | □M 2KXF  | 90                           | Yrs.        | Months Days                           | Hours Will.                                |                                  |                   |                |  | LINA               |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  |                    | and<br>ow<br>t                     |          |  |  | 10c. City, To                | wn or Loca  | ation                                 |  |                                  |                   | 10c            | I. Inside City                               | Limits             |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  |                    | Maryl<br>-f sho                    | tor      | MARVIAND HARFO   | RD CO  |                              |             | ARER!                                 | DEEN                                       |                                  |                   |                | 1 □Yes 2                                     | MXNo               |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  |                    | r 28a                              | irec     |  | 10 00  |                              |             |                                       |  |                                  | 10g. Citizen of V | Vhat Country   | /?   |                    |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  |                    | th wit                             |          | P O BOX 183  |  |                              |             |                                       |  |                                  |                   |                |  |                    |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  |                    | tems<br>tems                       | nue      |  | Armed Forces?                                  |                              | 13. W       | as Decedent of H<br>Yes, specify Cuba | ispanic Origin? (Sp<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.) | . 14. Rao<br>Blac |                |  |                    |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  | 36                 | rs afte                            |          |  | If Yes, Give                                   | 0                            | 1[          | □Yes 2⊠No                             | Specify:                                   |                                  | Specify           | ': BLAC        | 'K   |                    |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  | ş                  | 2 hou                              |          | 15. Decedent's Ed  | ucation  | 16                           | ia. Decede  | nt's Usual Occup                      | ation                                      | ing                              | 16b. Kind of Bu   | ısiness/Indu   | stry   |                    |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  | 212                | thin 7<br>e.<br>an "n<br>Medi      | oble     |  |  | -)                           | life. DO    | O NOT use retired                     | d)   | ing                              |                   |                |  |                    |
| RICHARD GEORGE    Sto. Intermets Name/Reductorship (Type. Print)   15b. Mailing Address (Street and Number or Poul Poul Poul Poul Poul Poul Poul Poul  |                    | ygien<br>ygien<br>rer th           | Co       |  |  |                              | REST        | JRANT                                 | 40. Markarda Nasa                          | - /5: 11:                        |                   |                |  |                    |
| 200. Membed of Disposition 3 (Renoval from State 4 (Donnigh St Diner (Speechy) 4 (Donnigh St Diner (Speechy) 4 (Donnigh St Diner (Speechy) 5 (Speech State S | gu                 | be od o                            |          | , , , ,  |  |                              |             |                                       |  |                                  | waiteri Surnan    | ie)            |  |                    |
| 200. Membed of Disposition 3 (Renoval from State 4 (Donnigh St Diner (Speechy) 4 (Donnigh St Diner (Speechy) 4 (Donnigh St Diner (Speechy) 5 (Speech State S | Ĕ                  | d Mel<br>mark                      | £        |  | vne. Print)                                    | 19                           | 9b. Mailing | Address (Street                       |  |                                  | er. Citv or Town. | State, Zip C   | ode)   |                    |
| 20. Here of Disposition (Name of Committee) 20. Here of Disposition (Name of Committee) 20. Date of Dispositio |                    | 12<br>ha                           |          |  |  |                              | Ū           | ·                                     |  |                                  |                   |                | ,  |                    |
| Agriculture      | ē,                 |                                    |          | 20a. Method of Disposition                                 |  | 20b. Place                   | of Disposi  | tion (Name of                         | 1  |                                  |                   |                | n, State                                     |                    |
| Physician / Middleal Examiner    Physician / Middleal Examiner | Ë                  | Page<br>nent o<br>int: If          |          |  |  | 1                            |             |                                       | 1  | 0-08                             | ABERDEE           | N, MAF         | RYLAND                                       |                    |
| Physician / Middleal Examiner    Physician / Middleal Examiner | alti               | rmit.<br>porta<br>porta<br>ly Inju |          | 21. Signa use of Funeral Service Licens                    | 90   | ,                            | 22.         | Name and Addre                        | ss of Facility WM                          | C BROW                           | N COMMU           | NITY F         | UNERA  | L                  |
| Physician Middled Examiner    Physician Middled   Physician   Phys | <u> </u>           | 90 = 50                            |          | Jarvara CI   | roun   |                              |             |                                       |  |                                  |                   |                |  |                    |
| Sequentially list conditions    |                    |                                    |          | shock, or heart failure. List only of                      | lications that caused<br>one cause on each lin | the death. D                 | o not enter | the mode of dyir                      | ng, such as cardiac                        | or respiratory a                 | rrest,            | į              | Approximate<br>nterval Betwo<br>Onset and De | en<br>eath         |
| Due to (or as a consequence of):    Sequentially list conditions, cause. Enfort Underlying cause (Disease or injury resulting in death). Last    FERMALE   23d. Date of delivery                      |                                    |          | disease or condition                                       | a. Seven                                       | e De                         | men         | tian                                  | VITA F                                     | ailu                             | ce to             |                |  |                    |
| Co. Due to (or as a consequence of):    Due to (or as a consequence of):   |                    |                                    |          |  | Due to (or es e                                | consequenc                   | e ot):      |                                       |  | thr                              | Sio.              |                |  |                    |
| Co. Due to (or as a consequence of):    Due to (or as a consequence of):   | 1                  | 7:10                               | Jer      | Sequentially list conditions, if any, leading to immediate |  | consequenc                   | e ol).      |                                       |  | 1 11                             | 100               |                |  |                    |
| Section   Sect   |                    | nd ransit                          | amir     | that initiated events                                      | c  |                              |             |                                       |  |                                  |                   |                |  |                    |
| 230. Date of delivery Month Day Year    FEMALE;   1   FEMALE;   2   1   2   2   2   3   2   2   3   2   2   3   2   2  | Ö,                 | e exe                              |          | resulting in death) Last                                   | Due to (or as a                                | consequenc                   | e of):      |                                       |  |                                  |                   |                |  |                    |
| 230. Date of delivery Month Day Year    FEMALE;   1   FEMALE;   2   1   2   2   2   3   2   2   3   2   2   3   2   2  | 876                | cate b                             | dica     |  | d  |                              |             |                                       |  |                                  |                   |                |  |                    |
| State    State |                    |                                    |          |  | 23c. If yes, outcome p                         | of pregnancy                 |             |                                       |  |                                  | 23d. Da           | ite of deliver | ,  |                    |
| 1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy performed? In Yes   2   No   3   Probably   4   Unknown   24b. Were autopsy findings available autopsy performed? In Yes   2   No   5   Perchange   25. Was case referred to medical examiner?   10   Yes   2   No   5   Perchange   25. Was case referred to medical examiner?   10   Yes   2   No   10   | B                  | death<br>atter                     | iciar    | in the past 12 months?                                     | 1□Live birth<br>4□Pregnant at                  | 2 Fetal dea                  |             |                                       | <u></u>                                    |                                  |                   |                |  | ar                 |
| 1   Yes   2   No   3   Probably   4   Unknown   24a. Was an autopsy performed? In Yes   2   No   3   Probably   4   Unknown   24b. Were autopsy findings available autopsy performed? In Yes   2   No   5   Perchange   25. Was case referred to medical examiner?   10   Yes   2   No   5   Perchange   25. Was case referred to medical examiner?   10   Yes   2   No   10   |                    |                                    | hysi     |  | 9□Unknown                                      |                              |             |                                       |  |                                  |                   |                |  |                    |
| 25. Was case referred to medical examiner?   |                    | es tha<br>gned<br>se del           |          | Part II. Other significant conditions of                   | ontributing to death bu                        | t not resulting              | in the und  | derlying cause giv                    | en in Part I.                              |                                  |                   |                |  |                    |
| 25. Was case referred to medical examiner?   | ord                | requir                             | ted      | Chronic  | renal  | <u>ta</u>                    | HU          | re                                    |  | 10                               | Yes 2             | 3 ☐ Proba      | bly 4 ∐Ur                                    | iknown             |
| 25. Was case referred to medical examiner?   | ည်<br>မ            | e 2 sh                             | nple     |  |  |                              |             |                                       |  | auto                             | psy               | prior to com   | sy findings av                               | /ailable<br>use of |
| State   Stat   |                    |                                    |          |  |  |                              |             |                                       |  | 1□ Yes                           | 2 2110            |                | 2 INO  |                    |
| be graded and place and due to the cause(s) and manner as stated.  29a. Certifier (Check only one) 29month of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year) 32. Flegistrar's Signature  | <b>\frac{1}{2}</b> | siciar<br>certif<br>rector         | 00       | examiner?  | Hospital:                                      | + 2DEB#                      | Outpotiont  | 2□ DOA Oth                            | er   |                                  |                   | (0             |  |                    |
| be graded and place and due to the cause(s) and manner as stated.  29a. Certifier (Check only one) 29month of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year) 32. Flegistrar's Signature  | ō                  | Phy<br>r this                      | $\vdash$ |  | 28a. Date of Injur                             | y 28t                        | o. Time of  |                                       |  |                                  |                   | (1) 27         | '  |                    |
| be graded and place and due to the cause(s) and manner as stated.  29a. Certifier (Check only one) 29month of the pass of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)  State 31. Date filed (Month, Day, Year) 32. Flegistrar's Signature  | <u>o</u>           | ath.<br>r: Afte                    | atio     | 2 ☐ Accident investigation                                 |  | rear)                        | injury      |                                       |  |                                  |                   |                |  |                    |
| 29a. Certifier (Check only one) 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.  29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)  30. Name and address of person who completed carae of death (Item 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Day, Year)  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | <u>Si</u>          | r Atte<br>er dez<br>irecto         | tific    | determined   | Zoe. Flace of Inju                             | ry - At home,<br>. (Specify) | farm, stre  | et, factory, office                   |  |                                  |                   | per or Rural   | Route Numb                                   | er,                |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Law Street Aberdeen  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                    | urs aft<br>rra! Di                 | Cer      |  |  |                              |             |                                       |  |                                  |                   |                |  |                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Law Street Aberdeen  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                    | Hosp<br>24 hou<br>Fune<br>etely fi | dical    | (Check only 2 Medical Exan                                 | iner: On the basis of                          | examination                  |             |                                       |  |                                  |                   |                |  |                    |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & Law Street Aberdeen  State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                    | o the                              | Med      |  | la + 1/2                                       |                              |             | 29c. Licens                           | e number                                   |                                  | 29d. Date signe   | d (Month, E    | lay, Year)                                   |                    |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                    | ->-0                               |          | > Manual   | EMUC   | >                            | SW          | T                                     | 21908                                      | 3                                | May               | 22             | ,200   | 58                 |
| State 31. Date filed (Month, Day, Year) 32. Registrar's Signature  |                    | 2                                  |          | 30. Name and address of person who                         | completed cause of de                          | eath (Item 23a               | a) (Type, P | rint) &                               | 10 W/                                      | tron                             | +/                | Xho!           | 1000   |                    |
| State MAY O. C. 2008   Progress of   |                    | J                                  |          | Manuel 4   | Zatin  | MJ                           | 2           | 0 '                                   |  | 1 EM                             | aryla             | A TOTAL        | 2100   | 4                  |
| Registrar NIAT 2 9 2000  |                    |                                    |          | MAY 2 9 2  | 008 September 1990                             |                              | A STORY     | arte                                  |  |                                  |                   |                |  |                    |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Thomas Fabrizio Jr. 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Salvare lal Birthplace (State or Foreign Country) Age (In yrs. last birthday) Year | If Under 24 Hrs. 8. Date of Birth Month, Day, **Funeral** Months 7929 218-22-1807 1 ☑ M 2 □ F Days Hours 79 PA Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Baltimore Essex 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 Essex Avenue 21221 USA Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐Yes 2 ĀNo If Yes, Give Year or Dates: 1 Never Married 2K Married Maryland 21215-0036 1 ☐Yes 2X No Specify 2 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "ranjury or other traumatic event, the Med once. Elementary/Secondary (0-12) College (1-4or 5+) Self-employed Car Wash Owner 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Fabrizio Sr. Alvira DiPaolo ပ 19a. Informant's Name/Relationship (Type. Print)
Kim Johnson / daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9526 Good Spring Drive Baltimore MD 21128 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 5/30/08 20a. Method of Disposition 20c. Location - City or Town, State 2 ☐Cremation 3 ☐ Removal from State 1 Burial Baltimore MD 4 Donati 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD Funeral Service Seensee 21. Signal Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) P.0. sate has been signed by the a page 2 should be detached to Yes 2 No 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 💢 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 X No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person

31. Date filed (Month, Day, Yes MAY 2 9

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 0 0 8 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** tederico 25 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a Keswick Multi-Care Center Baltimore 8. Date of Birth
July 27, 1929 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 213-24-4862 1 □ M 2 🔀 F 78 Months Days Hours Marvland Director Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits MD Baltimore Parkville 1 ☐ Yes 2 X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a or the M-dical Examiner must be r U.S.A. 8810 Walther Blvd 21234 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White \$ 3 X Widowed 4 □ Divarced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Cashier Grocery Store other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 ment of Health and Mental Frey Wilmer Catherine Millard of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Wellington Rd., Baltimore, MD Linda Kohler-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State tment of tant: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Injury or 5/29/08 Department Important: If Hillton Serv. Corp Towson, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Ligannee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Uh. 1050 York Rd., Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Metastatic Colon Cancer Un Known resulting in death) Medical Due to (or as a consequence of): xaminer Sequentially list conditions, if any, leading to immediate cause. E. Las Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical as the 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent prognant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) PO ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Mellitus 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No certificate has performed? Yes 2 No EMENTIA 1∐ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Man r of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural

Division or Vital Records,

Certification: 5 ☐ Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated: 29c, License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059056 7108 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 Th WEST Baltimore MO Salui MO 700 ST cet 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2008

#### State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) **Physician** Virginia Louise Gibson /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Charlestown Care Center Catonsville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔏 F Months Days Hours Director 476-24-9228 81 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 21s marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified and once. 10c, City, Town or Location 10a. State 10b. County Catonsvilla Director MD Baltimore 10e. Street and Number 715 Maiden Choice Lane by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) $\overset{\text{Elementary/Secondary (0-12)}}{12}$ College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be Ralph Leslie **Tuttle** ပ 19a. Informant's Name/Relationship (Type. Print) Thomas R. Gibson - husband 20a. Method of Disposition 20b. Pl 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Meta

4 ☐ Donation 5 ☐ Other (Specify)

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?

1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

disease or condition resulting in death)

IF FEMALE:

21. Signature of Funeral Service Licenses Steven H. Williams

23a. Part1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.

Part II. Other significant conditions contributing to death but not resu

varie

9

MAY 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| ратсш  | ME   | Catonia                                 | ATTTE   |                          |  |                             |                                     |  |                                      |  |                              |  |  |  |
|--|--|---|---|--------------------------|--|-----------------------------|-------------------------------------|--|--------------------------------------|--|------------------------------|--|--|--|
| nber   |  |   | 10f. Zi   | ip Code                  |  |                             |                                     | 10g. Citiz   | en of What                           | Country?   |                              |  |  |  |
| iden Choi  | ce Lane  |   | 2   | 21228                    | }  |                             | USA                                 |  |                                      |  |                              |  |  |  |
| ed 2 <b>1</b> Married<br>4 □ Divorced                        | 12. Was Decedent I<br>Armed Forces?<br>1 Yes 2 1<br>If Yes, Give<br>Year or Dates: |   | 13. Was Dece<br>If Yes, sp<br>1 ☐ Yes           |                          | lispanic Orig<br>an, Mexican<br>Specify: | gin? (Speci<br>i, Puerto Ri | )- 1                                | 1  |                                      |  |                              |  |  |  |
| 15. Decedent's Ed<br>ify only highest gradendary (0-12)      | ucation<br>de co <i>mplet</i> ed)<br>College (1-4or 5                              | (G<br>//ii                              | ecedent's Use<br>Give kind of w<br>fe. DO NOT o | ork done<br>use retired  | ation<br>during most<br>d)               | t of working                | 7                                   | 16b. Kind of Business/Industry  Own Home                     |                                      |  |                              |  |  |  |
| First, Middle, Last)   |  | 11011                                   | KHRIKCI   |                          | 18 Mothe                                 | r's Name (                  | First, Middle                       |  |                                      |  |                              |  |  |  |
| Leslie   | Tuttle   |   |   |                          |  | rgini                       |                                     | ennet  |                                      |  |                              |  |  |  |
| ame/Relationship (7  | Type. Print)<br>— husband  |   | lailing Addres <b>Maid</b>                      |                          |  |                             |                                     |  |                                      |  | 28                           |  |  |  |
| osition<br>XCremation 3<br>5 Other ( <i>Specify</i>          | Removal from State   | 20b. Place of D<br>cemetery,<br>Metro C | crematory or                                    | other plac               |  | Da<br>5/29/2                |                                     |  |                                      | or Town, State   | •                            |  |  |  |
| neral Service Licen<br>Steven                                | July   |   | 299   | atio:<br>Frede           | n Soci<br>erick                          | lety (<br>Road              | of Mar<br>, Balt                    | imore  | i, Inc                               | 21228  |                              |  |  |  |
| ne disease, or comp<br>rt failure. List only o<br>Final<br>n | plications that caused<br>one cause on each lir                                    | the death. Do not<br>ne.                | enter the mo                                    | of dyir                  | ng, such as                              | cardiac or                  | respiratory a                       | arrest,  | ,                                    | Approxi<br>Interval  | mate<br>Between<br>nd Death  |  |  |  |
|  | Due to (or as  | a consequence of)                       |   |                          |  |                             |                                     |  |                                      |  |                              |  |  |  |
| nditions,<br>imediate<br>rlying<br>injury                    | Due to (or as  | a consequence of)                       | :   |                          |  |                             |                                     |  |                                      |  |                              |  |  |  |
| ast  | Due to (or as  | a consequence of):                      |   |                          |  |                             |                                     |  |                                      |  |                              |  |  |  |
|  | u  |   |   |                          |  |                             |                                     |  |                                      |  |                              |  |  |  |
| t pregnant<br>months?<br>] No                                | 23c. If yes, outcome<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown           | 2 Fetal death                           | 3 □Ectopic  <br>5 □ Other (s                    |                          | у  |                             |                                     | 2  | 3d. Date of<br>Month                 | delivery<br>Day  | Year                         |  |  |  |
| icant conditions of  | ontributing to death b   | ut not resulting in the                 | e underlying                                    | cause giv                | en in Part I.                            |                             |                                     | tobacco us   | -                                    | e to the cause   |                              |  |  |  |
|  |  |   |   |                          |  |                             | 24a. Was<br>auto<br>perfe<br>1∐ Yes | an<br>ppsy<br>ormed?<br>2 No                                 | 24b. Were<br>prior<br>death<br>1 □ Y | autopsy findir<br>to completion<br>1?<br>/es 2 \( \square\) No | ngs available<br>of cause of |  |  |  |
| red to medical   |  |   |   |                          | 26. Place                                | of Death (                  | (Check only                         | one)   |                                      |  |                              |  |  |  |
| No   | Hospital: 1 ☐ Inpatie  | ent 2 ER/Outpa                          | atient 3 🗆 🗅                                    | OA Oth                   | er:                                      | rsing Hom                   | e 5□Res                             | idence 6   | □Other (S                            | Specify)   |                              |  |  |  |
| h<br>5 Pending<br>investigation                              |  | ry 28b. Tim<br>y Year) Inju             | ne of<br>iry<br>M                               | 28c. Injur<br>Wor<br>1 🗌 | yat<br>k?<br>Yes 2 □                     |                             | 3d. Describe                        | how injury   | occurred                             | _  |                              |  |  |  |
| 6 ☐ Could not be<br>determined                               | 28e. Place of injubuilding, etc  | ury - At home, farm<br>c. (Specify)     | , street, facto                                 | ry, office               |  | 28                          | 3f. Location (<br>City or To        | on (Street and Number or Rural Route Number,<br>Town, State) |                                      |  |                              |  |  |  |
|  | ysiclan: To the best<br>niner: On the basis o<br>and manner sta                    | f examination and/                      |   |                          |  |                             |                                     |  |                                      |  | se(s)                        |  |  |  |

29d. Date signed (Month. Day.

2. Date of Death Month

8. Date of Birth (Month, Day, Year)

NOV 10 1926

28

2008

Baltimore

Minnesota

4c. County of Death

May

4:50 p M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 □Yes 2XX No

**Physician** /Medical **Examiner** 

Examiner

Physician/Medical

\$

Completed

Be

P

Certification:

requires that the death certificate be executed nding physician and a sea as the burial-transit Division or Vital Records, P.O. Box 68760, been signed by the s should be detached To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t

> State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Year SAMUEL MELVIN GOODRICH hau 00 /Medical 4a Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Music more If Under 1 Year | If Under 24 Hrs. 8. 5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Date of Birth Month Day, Year) 05/05/1936 9. Birthplace (State or Foreign GA **Funeral** Months Days Hours Min. 255-58-1722 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Exercitor must be notified at 1 □Yes 2 No by Funeral Director BALDWIN MILLEDGEVILLE GA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 203 O'CONNOR DRIVE, N.W. USA 31061 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc be filed within 72 hours after 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be 17. Father's Name (First, Middle, Last) GOODRICH BERGMAN ELLIS FREIDA 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 203 O'CONNOR DRIVE, N.W., MILLEDGEVILLE, GA 31061 ELLEN GOODRICH/ WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 K Removal from State WEST VIEW CEMETERY 05/25/2008 MILLEDGEVILLE, GA 4 Donation 5 Dother (Specify) 21. Sign ture of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** っかと 1 Dan disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to in medic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician; The law requires that the death certificate be executed nesecti and Due to (or as a consequence of): the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ↑ Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 MNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Pruneral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🙀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) INAL BAUTMORE HOSPITAL GEN 32. Régistrar's Signatur Year) 31. Date filed (Month, Day, Registrar

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2998 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dау Month **Physician** 1/2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Security Number Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign
 Country) Age (In yrs, last birthday) **Funeral** Months Hours Min. 1 □ M 2 🗗 Davs EW JERSE Director dence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Yes 2□No **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4.9, 14. Race 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life., DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation / 5 □ Other (Specify) 21. Signature Funeral/Servi e Lic 1 e 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat - ause (Final disease or condition resulting in death) **Physician** ycenu /Medical Wellitus, Type 7 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tra Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending for use as IF FEMALE If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown Be Completed encephalopathy Disorder 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No certificate 1∏ Yes 25. Was case reference examiner? 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 ☐ Yes Medical Certification: To this 27. Manner of 1 1 E Natural 2 ☐ Acciden 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled ir Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Sign

State

DHMH 17 Rev 1/2001

Registrar

Day, Year)

9 2008

ORIGINAL

3100 St, Paul St, Suil 5, Baltiniore, MD 21218

08-03951 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Paul Howard State of Maryland / Department of Health and Mental Hygiene 2008 17354 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day May 23, 2008 Medical Examiner Paul E. Howard 111 1921 hrs 4c. County of Death 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Johns Hopkins Bayview Hospital **Baltimore City** 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. Funeral 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (MM/DD/YYYY Country) Months Days Hours Director Maryland 217-98-0945 11-12-1981 1XXM2 F Yrs Usual Residence of Deceden 10a, State 10d. Inside City Limits 10b. County 10c. City. Town or Location Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 No Marvland N/A Baltimore City Director 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 6544 St. Helena Avenue United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, 1XX Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 2 X No Yes 3 Widowed Specify: White Divorced Yes 2XX No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry pleted during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Iron Worker 9 Tron 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Denise D. Kuessner Paul E. Howard Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6544 St. Helena Avenue Baltimore MD 21222 Denise Kuessner 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Crestlawn Cemetery 05-30-2008 Marriottsville MD 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk Inc. 7922 Wise Avenue Dundalk Maryland 21222 23a. Part I. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line. Between Onset and /Medical Death a. Narcotic (methadone & heroin) intoxication Immediate Cause (Final disease ⊂xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit Physician/Medical X AMENDED, 28a-f, perMe, G880 6/11/08 TT #1, perME MNPENDED signed by the attending physician be detached for use as the burial Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed ficate has been si, page 2 should b 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 No 1 V Yes 2 No After this certific funeral director, p 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other; Hospital: 1 2 FR/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient 1 🗸 Yes 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natura 1 Yes 2 XNo unk Pending find 5/23/2008 Find6:30 pm

Division of Vital Records, P.O. Hospital or Attending Physician: 24 hours after death. Funeral

cal

State

Registrar

filled in by the f To the

2 Accident 3 Suicide 4

Jack Titus MD.

Investigation 6 X Could not be determined

(Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

and manner stated 29b. Signature and title of certifie

2008

30. Name and address of perso who completed ca e of death (Item 23a) Deputy Chief Medical Examiner 31. Date filed (Month, Day, Year) 32, Registrar's Signatur

28e. Place of Injury - At home, farm, street, factory, office building, etc.

found at home

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

6540 St. Helena Ave. Baltimore, MD

May 24, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 26<sup>Day</sup> 2008 **Physician** May w Gilbert R. Hale 2:30 pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Stella MAris Hospice Towson Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | (Month, Day, Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days 217-24-7445 Months Hours 1 M 2 □ F June 30, 1928 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. 10c. City, Town or Location 10a. State 10h County 10d. Inside City Limits a or 28a-f show the notified at MD Baltimore Essex 1 ☐ Yes 2 THO Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code lems 23a o 24 Avenal Road 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [35/es 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or White 1 ☐ Yes 2 🖾 No Specify: Specify. þ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Machinist Western Electric 12th Important: If Item 27 Is marked other any Injury or other traumatic event, 11 once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles R. Hale unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Guanti /daughter Baltimore MD 21221 24 Avenal Road 20b. Place of Disposition (Name of cemetery, crematory or other place)

Bayview Crematory 5/28/08 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Sarvice Licenses 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 ernel 23a. P 1. Enter the disea e, o shock, or heart failure. mplications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nly one cause on each line. Approximate Interval Between Onset and Death only one cause Immediate Cause (Final disease or condition resulting in death) **Physician** monare ears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) P.0. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒ No 24a. Was an autopsy performed? certificate 2 **2**(No 1∐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4⊠ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA P 1 Inpatient 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Drivin 17 Hev 1/2001

State Registrar

ORIGINAL

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT,

31. Date filed (Month, Day, Year)

M.D.

32. Pegistrar's Signature

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

|                          | 1 - State Registrar  1. Decedent's Name (First, Middle)  | ile, Last)                             |   | 30.11110   | ate of L                                |   | 2. Date of D                            | eath          |                                     | 801                        | 3. Time of Dea    |  |  |  |
|--------------------------|--|--|---|--|---|---|---|---------------|-------------------------------------|----------------------------|-------------------|--|--|--|
| an<br>al                 | Joseph P. Ha   | wkins                                  |   |  |   |   | Month 05-20                             | Da<br>1 – 2 0 | -                                   | Year                       | 19;45             |  |  |  |
| ner                      | 4a. Facility Name (If not institution  |  | nber)                                       | 4b. (  | City, Town, or                          | Location of Death                       |   |               |                                     | of Death                   | ,                 |  |  |  |
|                          | Ft. Washingt   | on Medica                              | al Cent                                     | er Fo  | rt Was                                  | shingto                                 | n                                       |               | PG                                  | 3                          |                   |  |  |  |
|                          | 5. Social Security Number  |  | 7. Age (In yrs. las                         | st birthday) If U                                | nder 1 Year<br>ths Days                 | If Under 24 Hrs.<br>Hours Min.          | 8. Date of Bi                           | rth           | )                                   | 9. Birthpla<br>Count       | ace (State or Fo  |  |  |  |
|                          | 217-30-6767   1 2 M 2 F   74   Yrs.   Months   Days   Hours   Min.   (Month, Day, Year)   Usual Residence of Decedent  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          | 10a. State 10b. Count  | •                                      |   | Town or Location                                 |   |   |   |               |                                     | 10                         | d. Inside City Li |  |  |  |
| Funeral Director         | MD Charl   | les                                    | La  | Plata  |   |   |   |               |                                     |                            | 1 <b>▼</b> Yes 2  |  |  |  |
| ire                      | 10e. Street and Number   |  |   | 10f  | . Zip Code                              |   |   | 10g. Ci       | tizen of V                          | Vhat Count                 | ry?               |  |  |  |
| al                       | 6279 Port Ta   | abacco R                               | D.  |  | 2064                                    | 6                                       |   | U.S           | S.A.                                |                            |                   |  |  |  |
| ne                       | 11. Marital Status   | 12. Was Dece                           | dent Ever in U.S.                           | 13. Was D  | ecedent of Hi                           | spanic Origin? (Sp<br>n, Mexican, Puert | pecify Yes or N                         | 0-            |                                     | e - America<br>k, White, e |                   |  |  |  |
| by                       | 3 ☐ Widowed 4 ☐ Divorce  | rried 1 Tes                            | 2 [] <b>X</b> No                            |  | es 2 XINo                               |   | , |               |                                     | Blac                       |                   |  |  |  |
| Completed                | 15. Decede   | nt's Education<br>est grade completed) | -   | 16a. Decedent's                                  | Usual Occupa                            | ation<br>Juring most of work            | kina                                    | 16b. K        | ind of Bu                           | siness/Ind                 | ustry             |  |  |  |
| du                       | Elementary/Secondary (0-12)  |  | -4or 5+)                                    | Glaz   | OT use retired                          | )                                       | ung                                     | Dt.           | EII                                 | zabe                       | th Hos            |  |  |  |
| So                       | 8th  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| Be                       | 17. Father's Name (First, Middle   | •                                      |   |  |   | 18. Mother's Nam                        | ,                                       | e, Maider     | Surnam                              | ie)                        |                   |  |  |  |
| ျ                        | Levi Hawkins Sr. France Gray   |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          | 19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta   |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          | Margaret Hawk  | cins/Wife                              |   | 6279 P   | ort Ta                                  | abacco                                  | Rd. La                                  | Pl            | ata,                                | MD_2                       | 20646             |  |  |  |
|                          | 20a. Method of Disposition  Burial 2 Cremation   | 3 ☐Removal from 5                      | State 20b. Pla                              | ce of Disposition<br>netery, crematory<br>Charle | (Name of<br>or other plac               | e) : - 24                               |   |               |                                     |                            | ,                 |  |  |  |
|                          | 4 □ Donation 5 □ Other (   |  | St.   |  |   | 1                                       |   | l             |                                     |                            | , MD              |  |  |  |
|                          | 21. Signature of Funeral Service   | Licensee                               | 11_   | - 1  |   | s of FacilityRO1                        |   | -             |                                     |                            |                   |  |  |  |
|                          | 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          |  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          | disease or condition resulting in death)  a.   Due to (or as a consequence of):  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          | Immediate Cause (Final disease or condition resulting in death)  a. Laton Cancel  Due to (or as a consequence of):  Bowel Obstruction  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| er                       | Sequentially list conditions, if any, leading to immediate across the latest la |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| Examiner                 | Bequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  C. Preumerum  C. Preumerum  C. C. Preum  C. C. P |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          | resutting in deatin) Last Due to (or as a consequence of):   |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| ख                        |  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| edical                   | 0  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          |  |  | v   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| sician//                 | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   |  | irth 2 □ Fetal d<br>ant at time of dea      |  | ic pregnancy<br>r <i>(specify)</i>      |   |   |               | 23d. Date of delivery  Month Day Ye |                            |                   |  |  |  |
| Phys                     | 9 ☐ Unknown  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| by P                     | Part II. Other significant condit  | tobacco                                | bacco use contribute to the cause of death? |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          |  | Yes 2                                  | 2 No 3 Probably 4 Unknow                    |  |   |   |   |               |                                     |                            |                   |  |  |  |
| Completed                |  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| g l                      | 24a. Was an autopsy performed?   |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
|                          |  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| Be                       |  | Hospital:                              | matiant and                                 | 3/0-4-4  | DOA Othe                                | 26. Place of Dea                        |   |               |                                     |                            |                   |  |  |  |
|                          |  | 1 □ Ir<br>28a. Date o                  |   | R/Outpatient 3☐<br>8b. Time of                   | J DOX                                   | 4 LI Nursing H                          | ome 5 Res                               |               |                                     |                            | )                 |  |  |  |
| ၉                        | 1 Natural 5 Pendi  | /A 8 A                                 | h, Day Year)                                | Injury M   | 28c. Injun<br>Work                      | rat<br>:?<br>Yes 2 □ No                 | Lou. Describe                           | now inju      | ny occurr                           | eu                         |                   |  |  |  |
| ၉                        | 2 Accident Invest  | I not be                               | of injury - At hom                          | e, farm, street, fa                              |   |   | 28f Location                            | Street        | nd Numb                             | er or Buni                 | Route Number,     |  |  |  |
| ၉                        | 3 dicide   | buildir                                | ng, etc. (Specify)                          | .,, 16.  | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |   | City or To                              | wn, Stat      | e)                                  | or or riurdi               | , route Number,   |  |  |  |
| ၉                        | 4 Homicide determ  |  |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| Certification: To        |  | ng Physician: To the                   |   |  |   |   |   |               |                                     |                            |                   |  |  |  |
| Certification: To        |  | I <b>I Examin</b> er: On the ba        | isis of examination                         |  |   |   |   |               |                                     |                            |                   |  |  |  |
| ၉                        | 29a. Certifier 1 Certifyi (Check only one) 2 Medica  | and mann                               | isis of examination                         |  | 29c. License                            | number                                  |   | 29d. Da       | te signer                           | (Month F                   | Day, Year)        |  |  |  |
| edical Certification: To | 29a. Certifier (Check only one)  29b. Signature and title of certifier   | er                                     | isis of examination in the stated.          |  |   |   |   | 29d. Da       | ate signed                          | d (Month, E                | Day, Year)        |  |  |  |
| edical Certification: To | 29a. Certifier (Check only one)  29b. Signature and title of certifity  21 Medica  | er                                     | isis of examination in the stated.          |  |   |   | -                                       | 29d. Da       | ate signed                          | (Month, E                  | oay, Year)        |  |  |  |
| edical Certification: To | 29a. Certifier (Check only one)  29b. Signature and title of certifier   | er                                     | isis of examination in the stated.          |  |   | 57632<br>12d Fa                         |   | 29d. Da       | signed 5/                           | 22/                        | oay, Year)        |  |  |  |

08-03942 Ervin Huber Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 17357

|   |  | 1- For State<br>Registrar  |   | Cei                   | rtificate    | of.      | Death                                 |  |                      |             | R             | eg. No.     | ۲,           | UU       | U  | 133    |  |  |  |
|---|--|--|---|-----------------------|--------------|----------|---------------------------------------|--|----------------------|-------------|---------------|-------------|--------------|----------|--|--------|--|--|--|
| Physicia  |  | 1. Decedent's Name (First, Middle  |   |                       |              |          | 2.                                    | Date of Dea                            |                      | - 3         | 3. Time of D  | eath        |              |          |  |        |  |  |  |
| ledical Exami   | ner  | Irvi   |   |                       |              | .        | Month Day Year 1325 hrs               |  |                      |             |               |             |              |          |  |        |  |  |  |
| to Man  |  | 4a. Facility Name (if not institution  | b. City, Town,                          | or Lo                 | cation of    |          |                                       | 4c                                     |                      |             |               |             |              |          |  |        |  |  |  |
|   |  | 519 Queen Anne Ave   | nue                                     |                       |              |          | Odenton                               |  |                      |             |               | A           |              | 1        |  |        |  |  |  |
| Funeral   |  | 5. Social Security Number  | 6. Sex 7.                               | Age (In yrs. I        | ast hirthday |          | If Under 1 Y                          | ear                                    | If Under             | 24Hrs       | 8 Date of Bi  | rth/MM/     | מאאאממי      | 9. Birth | nlace (State   | e or   |  |  |  |
| Director  |  | · ·  |   |                       |              | , ,      |                                       | ays                                    | Hours                | Min.        |               |             | 1            | Foreign  |  |        |  |  |  |
| Director  |  | 217-24-3482  | 1 X M 2 F                               | 78                    |              | Yrs.     |                                       |  |                      | 24          | Sept          | 19,         | 1929         | Cour     | 3. Time of Death 1325 hrs  th el inthplace (State or lign country) Marylar  10d. Inside City Lin 1 | yland  |  |  |  |
| _   |  | Usual Residence of Decedent  |   |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
|   |  | 10a. State 10b. County 10c. City, Town or Location   |   |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
| nd<br>shov  | ᅵ  | Maryland Anne Arundel Odenton  |   |                       |              |          |                                       |  |                      |             |               |             |              | 1 Yes    | 2 X No   |        |  |  |  |
| daryland<br>28a-f show any<br>1 at once.  | Maryland Anne Arundel Odenton  10e. Street and Number  10f. Zip Code  21113  |  |   |                       |              |          |                                       |  |                      | Τ.          | 10g. Citi     | zen of Wha  | t Count      | ry?      |  |        |  |  |  |
| th the Maryland<br>23a or 28a-f sho<br>notified at once.  | ا≝   | E10 Oursen Amm   |   |                       | 21           | 111      | 2                                     |  |                      |             | IIn i to      | .a c        | tataa        |          |  |        |  |  |  |
| ith tl<br>23s<br>noti   | <u>=</u>   | 519 Queen Anne   | 12. Was Deced                           | lent Ever in III      | ¢ 13         | Was      | Decedent of I                         |  |                      | n2 / Spec   | ify Vec or N  | 1           |              |          |  | Nack   |  |  |  |
| ath w   | Funeral  | 1 Never Married 2 X Ma   | arried Armed Ford                       |                       |              |          | s, specify Cub                        |  |                      |             |               |             | White,       |          |  | nuok,  |  |  |  |
| ar de   | 교  |  | 1 X Yes                                 | 2 No                  |              | Π.       |                                       |  |                      |             |               | İ           | 0 16         |          |  |        |  |  |  |
| hours afte<br>'natural'',<br>Examiner   | ≦  |  | orced If Yes, Give Yeer or Dates:       |                       |              |          | Yes 2 X                               |  |                      |             |               | T.a.        | Specify:     |          |  |        |  |  |  |
| hour:<br>natu   | Completed  | 15. Decedent's Education (Spec   |   |                       |              |          | s Usual Occup<br>st of working I      |  |                      |             |               | 16b. I      | Kind of Busi | ness/In  | dustry   |        |  |  |  |
| 6 1 72 an " an "  | į  | Elementary/Secondary (0-12)  | College (1-4                            | or 5+)                |              |          |                                       |  |                      |             | ,             |             |              |          |  |        |  |  |  |
| vithii<br>ere r   | Ĕ  | 12   |   |                       | (            | Off      | icer                                  |  |                      |             |               |             |              | Stá      | tes A  | rmy    |  |  |  |
| Fed year  |  | 17. Father's Name (First, Middle,  | Last)                                   |                       |              |          |                                       | 18                                     | .Mother's            | Name (F     | irst, Middle, | Maiden      | Surname)     |          |  |        |  |  |  |
| 21215-0036 uld be filed within 72 hours a Mental Hygiene. marked other than "natural c event, the Medical Examin  | Be   | John Edward  | Huber                                   |                       |              |          |                                       |  | A٦                   | vis (       | Camero        | n           |              |          |  |        |  |  |  |
| MD 21215-0036<br>2 should be filed within 72 hours after death with the Maryland<br>h and Mental Hygiene.<br>27 is marked other than "natural", or items 23a or 28a-f she<br>matic event, the Medical Examiner must be notified at once   | 의  | 19a. Informant's Name/Relations  | hip (Type, Print)                       |                       | 19b. M       | ailing   | Address (Str                          | eet a                                  | and Numb             | er or Rur   | al Route Nu   | mber, C     | ity or Town, | State,   | Zip Code)  |        |  |  |  |
| imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene. Iant: If item 27 is marked other than ' or other traumatic event, the Medical   |  | Reiki S. Huk   | ber/wife                                |                       | 519          | 9 Q      | ueen A                                | nne                                    | e Ave                | enue        | Oden          | ton,        | , Mary       | lan'     | d 211  | 13     |  |  |  |
| e, P  |  | 20a. Method of Disposition   |   |                       |              |          | ion (Name of                          | ceme                                   | etery,               | [           | Date          | 20c.        | Location - C | ity or T | own, State   |        |  |  |  |
| ges  <br>t of   | - 1  | 1 Burial 2 XCremation  | 3 Removal from                          | State                 | crematory o  |          |                                       |  |                      | - /0-       |               |             |              |          |  |        |  |  |  |
| Baltimore, MD 21215-00. permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other th injury or other traumatic event, the Med  |  | 4 Donation 5 Other Sp  |   | Wes                   |              |          | el Cre                                |  |                      |             |               |             |              |          |  | nd     |  |  |  |
| 3al<br>ermi<br>bepar<br>mpo   |  | 21. Signature of Funeral Service   |   |                       | - [:         | DO<br>DO | me and Addre<br>naldso:               | n ]                                    | r Facility<br>Fune 1 | ral H       | lome &        | Cre         | emator       | у,       | P.A.   |        |  |  |  |
|   | _  | (Aucouta (92)  | homes                                   |                       | 1.           | L41      | I Anna                                | po.                                    | lis l                | Road        | Odent         | on,         | Maryl        | and      | 2111   |        |  |  |  |
| Physician   |  | 23a Part I. Enter the disease, or failure. List only one cause   | complications that cau<br>on each line. | sed the death         | . Do not en  | iter the | e mode of dyir                        | ig, st                                 | ich as ca            | rdiad or re | espiratory ar | rest, sho   | ock, or hear | ١        |  |        |  |  |  |
| /Medical<br>  |  | Immediate Cause (Final disease   | A 41                                    | tic Cardiov           | ascular      | Dise     | ase                                   |  |                      |             |               |             |              | - 1      |  |        |  |  |  |
| xaiiiiiei   |  | or condition resulting in death)   | Due to (or as a co                      | onsequence o          | f):          |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
|   |  | Sequentially list conditions,  | b                                       |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
|   | 힐  | if any, leading to immediate cause. Enter Underlying Cause   | Due to (or as a co                      | onsequence o          | f);          |          |                                       |  |                      |             |               |             |              | 1        |  |        |  |  |  |
|   | Examiner   | (Disease or injury that initiated  | c<br>Due to (or as a co                 | onseguence o          | ·U·          | _        |                                       |  |                      | _           |               |             |              | _        |  |        |  |  |  |
| wed ≯   | Ä  | events resulting in death) Last  | Due to (or as a cr                      | onsequence o          | 11).         |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
| xecul   |  | - WINDENDED  | a                                       |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
| 8760, ificate be executed by physician and is the burial - transit  | n/Medical  | UNPENDED   | AMENDED                                 |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
| 8760, tificate be ng physic as the burn   | Ž  | IF FEMALE:<br>23b. Was decedent pregnant in th   | 23c. If yes, ou                         |                       | nancy        | 7 -      |                                       |  | <b>1</b>             |             |               | 23          | d. Date of d |          |  | .,     |  |  |  |
| 688<br>certif   | iai  | past 12 months?  | I Live birt                             | h<br>nt at time of de |              | -        |                                       | 3                                      | Lctopic              | pregnand    | ;y            |             | Month        | Da       | ay   | Year   |  |  |  |
| Box 68<br>e death certi<br>the attendin<br>ed for use a   | Sic  | 1 Yes 2 No 9 Unk   | nown 9 Unknow                           |                       | eath 5       | _ Oth    | er (Specify)                          |  |                      |             |               |             |              |          |  |        |  |  |  |
| the de red fined from   | Physicia   | Part II. Other significant conditi   |   |                       | esulting in  | theur    | derlying caus                         | o civ                                  | en in Per            | + 1         | 23e Did       | hobacco     | use contrib  | ute to t | he cause of  | death? |  |  |  |
| ords, P.O.  w requires that the steen signed by should be detach  |  | Ture ii. Other Significant Conditi   | contributing to d                       | leath but not i       | esulting in  | uic ui   | idenying dads                         | e giv                                  | CI III F ai          | ( 1.        |               |             |              |          |  |        |  |  |  |
| S, F  | Completed by   |  |   |                       |              |          | · · · · · · · · · · · · · · · · · · · |  |                      |             |               |             |              |          |  |        |  |  |  |
| rd<br>v req   | ē  |  |   |                       |              |          |                                       |  |                      |             | 24a. Was      |             |              |          |  |        |  |  |  |
| e lav   | Ē  |  |   |                       |              |          |                                       |  |                      |             |               | ormed?      | de           | ath?     |  |        |  |  |  |
| tal Reco<br>cian: The law<br>certificate has  |  | OF Man soon referred to modical  |   |                       |              |          | 00 DI                                 |  | f Dooth (            | Chaskan     |               | 2 N         | 10           | ✓ Yes    |  | INO    |  |  |  |
| Division of Vital Records, P.O. Box 68760, vithin 14 the Uspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans | a  | 25. Was case referred to medical examiner?   | Hospital:                               | etiest o              | ED/0.4-      | *ic-*    |                                       |  | these =              | Check on    | Home 5        | Decision    | nno e - 4    | 0.5      | Sac  |        |  |  |  |
| Physical dire   | 욘  | 1 <b>V</b> Yes 2 No  | 1 11                                    | patient 2             | ER/Outpa     |          |                                       | ــــــــــــــــــــــــــــــــــــــ |                      |             |               |             |              |          | Scene  |        |  |  |  |
| J of<br>Jing Ph<br>After t<br>funeral   |  | 27. Manner of Death  1 ✓ Natural 5 Dead  | 28a. Date of (Month, D                  | injury<br>Pay,Year)   | 28b. Time    | e or in  | · ·                                   |  | at Work?             |             | 8d. Describe  | now inj     | ury occurre  | 3        |  |        |  |  |  |
| itend<br>teath<br>the:  | اؾؘ  |  | ling<br>stigation                       |                       |              |          | 1_                                    | Ye                                     | s 2                  | No          |               |             |              |          |  |        |  |  |  |
| Division<br>tal or Attendi<br>is after death.   | The state of the s |  |   |                       |              |          |                                       |  |                      | or Run      | al Route Nu   | ımber, City |              |          |  |        |  |  |  |
| ral I   | 티  |  | rmined (Specify)                        |                       |              |          |                                       |  |                      |             | or rown,      | State)      |              |          |  |        |  |  |  |
| Hosp<br>24 ho<br>Fune   |  | 29a Gerritier  |   |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
| Division To the Hospital or Attendent of the Hospital or Attendent of the Funeral Director:   | <u>i</u>   | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) |   |                       |              |          |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |
| 5 ± ₹ 5   | Š  | 29b. Signature and title of certifie   | and manner state                        | led.                  |              |          | 29c. Lice                             | nseı                                   | number               |             |               | 29d.        | Date signer  | d (Mon   | th, Day,Yea  | ar)    |  |  |  |
| _ \   |  | 11. 7  | 11/                                     | Λ .                   |              |          | 1 00                                  | C.M                                    | F                    |             |               | Ma          | y 24, 200    | 18       |  |        |  |  |  |
| 25  |  | Wynte J  | me Tru                                  | U                     |              |          |                                       | J VI                                   |                      |             |               |             | ,, 200       |          |  |        |  |  |  |
| 30,   | 1  | 30. Name and address of person   |   | ,                     | ,            | 4.5      | 01                                    | Б.                                     | Alms -               | MD 0        | 1004          |             |              |          |  |        |  |  |  |
| U   | i  | Margarita Korell MD.   | Assistant Medic                         |                       |              | 1 Pe     | enn Street,                           | Bal                                    | umore,               | MD 21       | 1201          |             |              |          |  |        |  |  |  |
|   | ate  | 31. Date filed (Month, Day, Year)  | 200                                     | strar's Signati       | ire          | -        | 40                                    |  |                      |             |               |             |              |          |  |        |  |  |  |
| Regis   | ırar   | MAY 2 9  | 2008 188                                | لكرسويه               | E Sta        | 284      | 23                                    | _                                      |                      |             | _             |             |              |          |  |        |  |  |  |
| Ornviri 17 Rev 1/2  | 001  | 0.5(1) 0.5   |   |                       | ORIGI        | NAL      |                                       |  |                      |             |               |             |              |          |  |        |  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 27. 2008 Joseph Krebs May 05:30 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore 7717 Wilson Avenue Parkville 8. Date of Birth (Month, Day, Year) 04/12/1925 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) Funeral Months Hours Days 1 💢 M 2 🗆 F 83 Yrs Maryland 218-16-2235 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Modical Exarcia or 1.00 to the profitted at once. 1 ☐ Yes 2 🔀 No Director Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7717 Wilson Avenue 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ဤYes 2 ☐ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. δ 3 X Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph W. Krebs Helen McNeil ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Joseph W. Krebs - Son 4508 Wintersweet Lane Murrells Inlet, SC 29576 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State | Cemetery, ciematory or other place)
4 Donation 5 NOther (Specify) Entombment Gardens of Faith Cem. 05/30/2008 Baltimore, Maryland 21. Sign of Funeral Service Licensee 5305 Harford Road 22. Name and Address of Facility Unles Baltimore, Maryland 21214 Leonard J. Ruck, Inc. Mundo Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Arending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t 23c. if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown ner significant conditions contributing to death cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 1 ☐ Yes 2 No this certific al director, 25. Was case referred to medical examiner? Be ( 26. Place of Death Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after eath Director d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Baltimor, MI

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

**ORIGINAL** 

cause of death (Item 23a) (Type,

|   |                               | Please Type State 1 - State Registrar  |  | and / Depa                           |  | Health and N                                   | /lental Hygie                | _  | 8 1735   |  |  |
|---|-------------------------------|--|--|--------------------------------------|--|--|------------------------------|--|--|--|--|
| Physicia<br>/Medic  |                               | Decedent's Name (First, Middle, Last)     Catherine Anne   | Kei  | lty                                  |  |  | Date of Death     Month      | Day Year 25 2008                                   | 3. Time of Death 11:50 A <sup>M</sup>            |  |  |
| Examin Funeral Director   | er                            | 4a. Facility Name (If not institution, give street an Greater Baltimore Med:  5. Social Security Number 6. Sex 1 □ M 2 ▼   | ical Cent  | ter<br>rs. last birthday)<br>49 Yrs. | _  | WSON If Under 24 Hrs. Hours Min.               | 8. Date of Birth<br>Jan 15,  | 4c. County of Dea<br>Baltimo<br>9. Bit<br>1959 Cal |  |  |  |
| 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.  Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Eventing Inc. must be notified at   | ector                         | Usual Residence of Decedent  10a. State 10b. County  MD Baltimore  | 10c.   | City, Town or La                     | enix   |  |                              |  | 10d. Inside City Limits 1 □Yes 2X No             |  |  |
| ms 23a or   | Funeral Director              | 10e. Street and Number 12 Colonial Oaks Cour 11. Mar/tal Status 12. Was  | Decedent Ever in                                     | U.S. 13.                             |  | 131<br>Ilspanic Origin? (Span, Mexican, Puerto |                              | U.S.A.   |  |  |  |
| nours after<br>ural", or ite  | by                            | 1 Never Married 2 X Married 1 1  | d Forces?<br>es 2 <b>∑</b> No<br>, Give<br>or Dates: |                                      | 1 □Yes 2 □XNo  | Specify:                                       | Rican, etc.)                 | Black, White, etc.  Specify: White                 |  |  |  |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantines must be multiled at once. | Completed                     | 15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12)  Cotte  4   | fed)<br>ge (1-4or 5+)                                | (Give                                | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br>MEMAKET     | eation<br>during most of work<br>d)            | ing 16                       | /Industry  |  |  |  |
| nould be file<br>a Mental Hy<br>narked othe<br>natic event  | To Be (                       | 17. Father's Name (First, Middle, Last)  Harry Joseph  | Sailo  |                                      |  | Eleano   |                              |  |  |  |  |
| Health and tem 27 is nother traun   | 7                             | 19a. Informant's Name/Relationship (Type. Print) Thomas W. Keilty-husb: 20a. Method of Disposition   | end  | 12 C                                 | olonial C  | Jaks Ct.,                                      | Phoenix,                     | MD 2113  c. Location - City or                     | 131  |  |  |
| mit. Pages<br>partment of<br><b>sortant: If</b> is<br>/ injury or of of of or or or or or or or or or or or or or   |                               | 1 Mourial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Vicensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral   |  |                                      |  |  |                              |  |  |  |  |
| Der Der Der Der Der Der Der Der Der Der   |                               | 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause  | nat caused the de                                    |                                      | 1050 York  | Rd., Tou                                       | uson, MD                     | 21204  | Approximate<br>Interval Between                  |  |  |
| pricia pe   | ical Examiner                 |  |  |                                      |  |  |                              |  |  |  |  |
| The law requires that the death certificate ate has been signed by the attending phys bage 2 should be detached for use as the  | Completed by Physician/Medica | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | у  |                                      | 23d. Date of de<br>Month   | 3d. Date of delivery<br>Month Day Year         |                              |  |  |  |  |
| w requires that<br>been signed t<br>should be deta  | ed by PI                      | Part II. Other significant conditions contributing   | en in Part I.  |                                      |  | contribute to the cause of death?              |                              |  |  |  |  |
| ician: The law r<br>certificate has be<br>ector, page 2 shu   | Complet                       | Renal Failu  | re   | ·                                    |  |  | 24a. Was an autopsy performe | d?/ prior to death?                                | utopsy findings available completion of cause of |  |  |
| g Phys<br>er this<br>eral dir   | Certification: To Be          | 25. Was case referred to medical examiner?  1  |  |                                      |  |  |                              |  |  |  |  |
| ital<br>rai   |                               | 4 Homicide determined 286. P   | lace of Injury - At uilding, etc. (Spec              | cify)                                | 28f. Location (Street and Number or Rural Route Numb<br>City or Town, State) |  |                              |  |  |  |  |
| To the Howithin 24 how the Full To the Full completely  | Medical                       | 29a. Certifier  (Check only only only)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner consists of examination and/or investigation, in my opinion, death occurred at the time, date and place, and do and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Mo. DOOS1347)  5/26/0 |  |                                      |  |  |                              |  |  |  |  |
| 10  |                               | 30. Name and address of person who completed of Cynthin Smann  | 100  | 701 N                                | Print) Charle  |  |                              | e MO   |  |  |  |
| Stat<br>Registra  | ır                            | 31. Date filed (Month, Day, Year)  MAY 2 9 2008  | 2. Registrar's Sign                                  | nature                               | li)  |  |                              |  |  |  |  |

08-03979 William Lucas Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 17360

|  |                  | 1- For State<br>Registrar  |   |              | Certific                              | ate of                 | Death                    |            |                     |             | R   | leg. No.     |                              | •                              | • , ,                             |        |  |
|--|------------------|--|---|--------------|---------------------------------------|------------------------|--------------------------|------------|---------------------|-------------|---|--------------|------------------------------|--------------------------------|-----------------------------------|--------|--|
| Physicia   | n/               |  | Decedent's Name (First, Middle,Last) 2. |              |                                       |                        |                          |            |                     |             |   |              | 3                            | . Time of Death                | $\neg$                            |        |  |
| ledical Examir   | ner              | William No   |   |              | r.                                    |                        |                          |            |                     |             | Month<br>May 24, 2  |              | Year                         |                                | 1644 hrs                          |        |  |
| Service .  |                  | 4a. Facility Name (If not instituti<br>Howard County Gene  |   |              | 4                                     | b. City, Tow<br>Columb |                          | ocation of | Death               |             | 4c. C   | Death        |                              |                                |                                   |        |  |
| Funeral  |                  | 5. Social Security Number  | 6. Sex                                  | 7. Age (I    | n yrs. last birl                      | hday)                  | If Under 1               | _          | _                   | ,           | 8. Date of Bi   | rth(MM/DD    |                              |                                | lace (State or                    |        |  |
| Director   |                  | 220-60-9626  | 1 X M 2 F                               | 54           | 4                                     | Yrs.                   | Months                   | Days       | Hours               | Min.        | 07/05   | /1953        | 3 [                          | oreign<br>Coun                 | try) Mary la                      | and    |  |
| any  | F                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |   |              |                                       |                        |                          |            |                     |             |   |              |                              |                                | 0d. Inside City Li                | imits  |  |
| <b>8</b>   | .                | MD Howard Elkridge   |   |              |                                       |                        |                          |            |                     |             |   |              |                              |                                | 1 Yes 2 x                         |        |  |
| arylano<br>8a-f sł<br>at onc   | ᅙ                | 10e. Street and Number   | valu                                    | t.           | LIKLI                                 | age                    | 10f. Zip Co              | ode        |                     | -           | 1   | 10g. Citizer | of What                      |                                |                                   |        |  |
| MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event, the Medical Examiner must be notified at once  | Funeral Director | 6620 Washingto   | n Blvd lo                               | t. 46        |                                       |                        | 210                      | 75         |                     |             |   | Unite        | d St.                        | ate                            | 3                                 |        |  |
| ms 23.   | erai             | 11. Marital Status   | 12. Was De                              | cedent Ev    | er in U.S.                            |                        |                          |            |                     |             |   |              | . Race - A                   | America                        | n Indian, Black,                  |        |  |
| r death<br>or ite<br>must  | Ē                | 1 Never Married 2 X  | 1Yes                                    | 2 X          | No                                    |                        |                          | _          |                     | rueito Ri   | can, etc.)  |              | White, 6                     |                                |                                   |        |  |
| rs afte<br>ural",  | र्व              | 3 Widowed 4 Di  15. Decedent's Education (Spe  | vorced If Yes, Give Ye or Dates:        |              | sted) 16a                             |                        | Yes 2 X                  |            |                     | ind of wor  | k done  |              | ec <i>ify:</i><br>d of Busin | Whi                            |                                   |        |  |
| 2 hou<br>"nati   | ted              | Elementary/Secondary (0-12)  |   | 1-4 or 5+)   |                                       |                        | st of working            |            |                     |             |   | TOD. Talk    | u Oi Dusii                   | 1033/1110                      | ida y                             | Ì      |  |
| 21215-0036 uld be filed within 7. Mental Hygiene. marked other than c event, the Medical   | Completed        | 12   |   |              | Pa                                    | inte                   | r / G                    | laze       | er                  |             |   | Co           | ıntv                         | Goz                            | zernment                          | .      |  |
| 5-0<br>led w<br>Hygie<br>othe  |                  | 17. Father's Name (First, Middle   | e, Last)                                |              |                                       |                        |                          | 18         |                     |             | irst, Middle,   | Maiden Su    | rname)                       |                                | <u> </u>                          |        |  |
| 121<br>d be fi<br>lental<br>arked  | B                | William Norma  | n Lucas,                                | Sr.          | 1                                     |                        |                          |            |                     | is F        |   |              |                              |                                |                                   |        |  |
| nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene. It If item 27 is marked other than other traumatic event, the <u>Medical</u>   | ٩                | 19a. Informant's Name/Relation Valerie C. Luc  | 19                                      |              |                                       |                        |                          |            | al Route Nu         |             |   |              | (ip Code)<br>4D 21075        | 5                              |                                   |        |  |
| and 2 Jealth item 2  | ŀ                | 20a. Method of Disposition   | i                                       |              | 20b. Place                            | of Disposit            | tion (Name               |            |                     |             | Date  |              |                              | •                              | own, State                        | -      |  |
| Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other thinjury or other traumatic event, the Meden of the M |                  | 1 X Burial 2 Cremation   |   | from State   | Meado                                 | ory or other           | Man                      | nori       | .al                 | 05/29       | 9/2008  | 3  E1 kr     | ridee                        | ۷ .                            | aryland                           |        |  |
| altir<br>mit. F<br>partme<br>portau<br>ury or  | ı                | Donation 5 Other S   |   | 1.0          | 1 A                                   | 22. Na                 | ame and A                | dress c    | of Facility         | Ambr        | ose Fi  | meral        | Ноп                          | ne                             | Inc                               | $\neg$ |  |
| E E E E  |                  | JUM D  | Dull                                    | WW           | У                                     | 1 - 1                  | 328 SI                   | ırpn       | iur 5               | prin        | g Ka.   | Arbut        | tus,                         | Mar                            | yland 2.                          |        |  |
| Physician<br>/Medical  |                  | 23a. Part I. Enter the disease, o failure. List only one cause   |   | caused the   | death. Don                            | ot enter the           | e mode of o              | dying, s   | uch as ca           | rdiac or re | espiratory ar   | rest, shock  | , or heart                   |                                | Approximate Into<br>Between Onset |        |  |
| -xaminer   | İ                | Immediate Cause (Final disease or condition resulting in death)  | e a. Atheroscle  Due to (or as          |              |                                       | lar Dise               | ease                     |            |                     |             |   |              |                              | $\dashv$                       | Death                             |        |  |
|  |                  | Sequentially list conditions,  | b.                                      | a consequ    | ence or).                             |                        |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
|  | je.              | if any, leading to immediate cause. Enter Underlying Cause   | Due to (or as                           | a consequ    | ence of):                             |                        |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
| .0   | Examin           | (Disease or injury that initiated events resulting in death) Last  | ence of):                               |              |                                       |                        |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
| and transi   |                  |  | d                                       |              |                                       |                        |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
| frate be executed g physician and transi   | /Medical         | UNPENDED   | X AMENDED<br>#1 per                     | ME.a88       | 30 6/11/                              | TT 80                  |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
| 8760, ificate be   | ١                | IF FEMALE:<br>23b. Was decedent pregnant in t  | 23c. If yes                             | , outcome    | of pregnancy                          |                        |                          | 2          | Estania             | pregnanc    |   |              | elivery                      | y Year                         |                                   |        |  |
| Box 687 e death certific the attending ged for use as the  | siciar           | past 12 months?  |   |              |                                       |                        | al death<br>ier (Specify |            | _ LCtopic           | pregnanc    | cy Month Day Yea  |              |                              |                                |                                   |        |  |
| Bo;<br>e deat<br>the at  | Physi            | and the second second second   | nknown g Unkr                           |              |                                       |                        |                          |            |                     | -11         |   |              | _                            |                                |                                   |        |  |
| P.O. s that the greed by   | by P             | Part II. Other significant condi   | itions contributing                     | to death bu  | ut not resultin                       | g in the ur            | nderlying ca             | ause giv   | en in Par           | t I.        | 23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown |              |                              |                                |                                   |        |  |
| Is, P.C<br>quires that<br>en signed  |                  |  |   |              | · · · · · · · · · · · · · · · · · · · |                        |                          |            |                     |             |   |              |                              | ere autopsy findings available |                                   |        |  |
| Records,  The law requirificate has been si  | Completed        |  |   |              |                                       |                        |                          |            |                     |             |   |              |                              |                                | o completion of cause of          |        |  |
| tal Rec<br>cian: The<br>certificate<br>ector, page   | 5                |  | <del> </del>                            |              |                                       |                        |                          |            |                     |             | 1 Yes   | 2 No         | 1 🗸                          | / Yes                          | 2 N                               | 0      |  |
| Vital hysicians this certi   | mॅ               | 25. Was case referred to medical examiner?   | Hospital:                               | Inpatient    | 2 <b>V</b> ER/O                       | utnatient              |                          |            | ther                | Check on    | y one)<br>Home 5  |              |                              |                                |                                   |        |  |
| of V<br>ing Phys<br>After thi  | 입                | 1 Yes 2 No<br>27. Manner of Death  | 28a. Date                               | e of Injury  | 28b.                                  | Time of In             |                          | <u> </u>   | at Work?            |             | 3d. Describe  |              |                              |                                |                                   |        |  |
| on cendin sath.  | 흷                |  | nding                                   | h, Day,Year) | )                                     |                        | 1                        | 1 Ye       | es 2                | No          |   |              |                              |                                |                                   |        |  |
| Division tal or Attendii rs after death. al Director; A led in by the fu   | <u>i</u>         | 2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2 |   |              |                                       |                        |                          |            |                     |             | 28f. Location (Street and Number or Rural Route Number, City or Town, State)            |              |                              |                                |                                   |        |  |
| Division of Vital Records, P.O. Box 68 Hospital or Attending Physician: The law requires that the death certife hours after death. Funeral Director: After this certificate has been signed by the attendintely filled in by the funeral director, page 2 should be detached for use as  | Certification:   | 4 Homicide dete  | ermined (Specify                        | )            |                                       |                        |                          |            |                     |             | or rown,  | olale)       |                              |                                |                                   |        |  |
| To the Hospital within 24 hours To the Funeral completely filled   |                  |  |   |              |                                       |                        |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
| 7 2 2 5 5  | Medical          | 29b. Signature and title of certifier 29c. Lice  |   |              |                                       |                        |                          |            | 29c. License number |             |   |              |                              |                                | h, Day,Year)                      |        |  |
|  |                  | Maria 1  | hade.                                   | a fi         |                                       | O.C.M.E.               |                          |            |                     |             |   | May 26, 2008 |                              |                                |                                   |        |  |
|  | }                | 30. Name and address of person   | n who completed cau                     | use of deat  | th (Item 23a)                         |                        |                          |            |                     |             |   |              |                              |                                |                                   |        |  |
| 12   |                  | Margarita Korell MD.   | Assistant Me                            |              |                                       | 111 Pe                 | enn Stree                | et, Bal    | ltimore,            | MD 21       | 201   |              |                              |                                |                                   |        |  |
| Sta<br>Registi   |                  | 31. Date filed (Month, Day, Year)  | 0000                                    | Registrar's  | and the same of                       | do                     | de                       |            |                     |             |   |              |                              |                                |                                   |        |  |
| Registi  | ali_             | MAI Z  | T LOOO A                                |              |                                       | 9                      | e i garage               |            |                     |             |   |              |                              |                                | CME                               |        |  |

filed within 72 hours after death with the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at Maryland 21215-0036 Baltimore, Department Important: I any Injury o

**Funeral** 

**Director** 

**Physician** /Medical Examiner

physician and s the burial-transit the death certificate be executed attending p ed by the The law requires ate has b certificate this certific al director, After this To the Hospital or Attending Pr within 24 hours efter death. To the Funeral Director After th completely filled in by the funeral

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Records,

or Vital

Division

**Physician** DLIDAM Paul /Medical 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 9, 1944 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Months 1 X M 2 □ F 64 West Virginia 219-42-6201 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1X Yes 2 No Director Marvland N/A Baltimore 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21224 733 Ponca Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 7 years Insulator Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Wilma Feathers Walter M. Lantz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 733 Ponca Street, Baltimore, Maryland 21224 Donna Lantz wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Of Jesus Cem. May 30, 2008 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 21222 7110 Sollers Point Road, Dundalk, MD. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. Unto only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Preumonia Due to (or as a consequence of) Parenchy mal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Restrictive Due to (or as a consequence of): Card Physician/Medical Dilated IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 TYes 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one)

Registra

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

2. Registrar's Signature

201 East

and manner stated.

MAY 2 9 2008

JOCELINE KOUATCHOU

Jocelyne KounteHOU,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

P16692

university Parkwely.

29d. Date signed (Month, Day, Year)

Mery 26, 2008

Beiltimore mo 21218

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2:25 A M **Physician** May 27, 2008 notharine /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Catonsville Charlestown Retirement Center Birthplace (State or Foreign Country) Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 □ XF 96 213-10-6631 Yrs. Maryland Director 29, 1911 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a, State Catonsville Baltimore MD 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number De l 21228 United States 708 Maiden Choice Lane, 230 North ms 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. "natural", or items 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify. White Specify. Completed by 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation the Medical (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene. 27 is marked other than r traumatic event, the Me than Elementary/Secondary (0-12) College (1-4or 5+) Education Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Anderson Gleghorn Howard Monroe Jefferson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3 Palo Court, Halethorpe, MD 21227 19a, Informant's Name/Relationship (Type, Print) Leanne Musick permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr 27 Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 5-29-2008 Park Wood Cemetery Baltimore, MD 4 ☐ Qonation 5 ☐ Other (Specify) 22. Name and Address of Facility Amorose Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Intestinal Weeks obstruction /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause between the Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes □ No 24a. Was an certificate has b autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ■ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide within 24 hours aft To the Funeral Di completely filled in 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print) Maiden Choice Ln 32. Registrar's Signature State MAY 2 9 2008 Registrar

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Day Stephanie Mattei MAY 2008 1423 26 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 52 Director AUG 8 1955 218-66-3158 Wash., D.C. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Galesville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O.BOX 224, 4733 Woodfield Road Funeral 20765 USA Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 XNo Specify: \$ 3 ☐ Widowed 4 ☐ Divorced White 'natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12Homemaker Own Home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event ODEs. Be 18. Mother's Name (First, Middle, Maiden Surname) John **Thompson** Elizabeth Louise Brockwell ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert Mattei, Jr. - husband P.O.BOX 224, 4733 Woodfield Road, Galesville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 In Cremation 3 ☐ Removal from State Metro Crematory, Inc. 5/28/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee Steven H. Williams Name and Address of Facility Cremation Society of Maryland, INC. 299 Frederick Road, Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Anoxic Encepalopatt **Physician** /Medical Due to (or as a consequence of) **Examiner** Cardiac Ares Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Sept & Shacke Due to (or as a consequence of): Preumoni Chronic Obstructure Pulnonay Disease Physician/Medical attending pl for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 TYes 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, 24 hours after death Funeral Director: filled in by the the

the Maryland

Baltimore, Maryland 21215-0036

within 24 hor To the Fune completely fi

State Registrar

Medical

HO WARD 10UNG

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year) 2005

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

2001 medical Parkway Annapolis MD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D000582917

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and

31. Date filed (Month, Day,

State of Maryland / Department of Health and Mental Hygiene 2008 1- State Amend 10b & 10c, perFH, 0879 5/29/08 Tertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $19^{\text{Day}}$ **Physician** May 2008 2:00 P M BOY JENNIFER MCNIECE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** TOWSON

If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year) <u>Greater Baltimore Medical Center</u> Baltimore Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday, 6. Sex 1 M 2 ☐ F **Funeral** Months Yrs Director 5/19/2008 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 Is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Modical Examiner must be modified at Completed by Funeral Director 1 ☐Yes 2 ☐ No BALTIMORE MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 225 E. MONTGOMERY ST. 21230 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🌠 No Specify: WHITE 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 0 INFANT INFANT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ GEORGE PERSKY JENNIFER MCNIECE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any Injury or other trau once. 101 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SEN Musit WIO W 21. Signature of Funeral Service Licensee 22, Name and Address 16924 0 York 18 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to for as a conservience of: /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the bunal-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 🗆 No 1 ☐ Yes 2XXV0 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending investigation s after dea... ral Director: Aftr 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0033017 of person who completed cause of death (Item 23a) (Type, Print) DEBORAH HEBB, 6701 N. CHARLES ST., BALTIMORE, MARYLAND M.D.21204 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records.

|                |  |                  | For State   | State  | of Marylar                           | •                                 | artment of F<br>rtificate of I  |                               | nd Me  |                                    | ene<br>g. No. <b>20</b> (             | 18                        | 17365                           |
|----------------|--|------------------|---|--|--------------------------------------|-----------------------------------|---|-------------------------------|--|------------------------------------|---------------------------------------|---------------------------|---------------------------------|
|                |  |                  | Registrar  1. Decedent's Name (First, Middle                                  | e, Last)   |                                      |                                   | inoute or   | - Cairi                       | 2  | . Date of Death                    |                                       | , 0                       | 3. Time of Death                |
| Е              | Physici  | an               |   | A 4  | inc. I.                              |                                   |   |                               |  | Month                              | Day Y                                 | ear<br>D8                 | 10:15AM                         |
|                | /Medic   |                  | Vernon U  4a. Facility Name (If not institution                               |  | arsch                                |                                   | 4b. City, Town, o   | r Location of                 | Death  | May                                | 4c. County of                         |                           | 10 15/1                         |
|                | Examin   | er               | SAINT JOSEPH M  |  |                                      |                                   | 4b. City, Town, o   |                               | WSO  | N                                  |                                       |                           | MORE                            |
| T              | Funeral  |                  | 5. Social Security Number   | 6. Sex   | 7. Age (In yrs.                      |                                   | If Under 1 Year<br>Months Days  | If Under 2<br>Hours           |  | . Date of Birth<br>(Month, Day,    | Year) 9                               | . Birthp                  | lace (State or Foreign          |
| П              | Director   |                  | 218-16-1827   | 1 <b>火</b> ∏ M 2□ F                                  | 82                                   | Yrs.                              | Wientino Bayo   | Hould                         | J  | une 18,                            | 1925                                  | Mary                      | Tand                            |
|                | and w  |                  | Usual Residence of Decedent  10a. State 10b. County                           |  | 10c Ci                               | ty, Town or Lo                    | cation  |                               |  |                                    |                                       | 10                        | Od. Inside City Limits          |
|                | f sho  | ō                |   | timore   |                                      | Parkv                             |   |                               |  |                                    |                                       |                           | 1 □Yes 2 📶 No                   |
|                | 28a-   | rect             | 10e. Street and Number  |  |                                      |                                   | 10f. Zip Code   |                               |  | 10                                 | g. Citizen of Wha                     | at Coun                   | trv?                            |
|                | buld be filed within 72 hours after death with the Maryland Mental Hyglene.  arked other than "natural", or items 23a or 28a-f show atte event, the Medical Experience must be notified at | Funeral Director | 8820 Walther B  | lvd., Apt  | . 3207                               |                                   | 21234   |                               |  |                                    | U.S                                   |                           |                                 |
|                | tems   | nue nue          | 11. Marital Status  | 12. Was Dec<br>Armed Fo                              | edent Ever in U<br>orces?<br>2 □ No  | .S. 13. \                         | Was Decedent of H   | lispanic Orig<br>an, Mexican, | in? (Speci<br>Puerto Ric                     | fy Yes or No-<br>can, etc.)        | 14. Race -<br>Black,                  | America<br>White, e       |                                 |
| 36             | or i   | by F             | 1 ☐ Never Married 2 ☐ Marr<br>3 ☐ Widowed 4 ☐ Divorced                        | ied 1 🔼 Yes<br>If Yes, G                             | ²□Noww<br>oatesKorea                 | <b>-</b>                          | 1 □Yes 2 🛣 No   | Specify:                      |  |                                    | Specify:                              | Whi                       | <b>+</b> 0                      |
| 8              | hour<br>tural  | PG P             | 15, Deceden   |  | ates/OT CO                           | 16a Dece                          | dent's Usual Occup  | ation                         |  | 1                                  | 6b. Kind of Busir                     |                           |                                 |
| Ž              | in 72  | jet              | (Specify only highes  | st grade completed)                                  |                                      | (Give                             | kind of work done   | during most                   | of working                                   | 40                                 | OB. INITIA OF BUSIN                   | 1033/1110                 | uony                            |
| 21215-0036     | withi<br>jene.<br><b>thar</b>  | Completed        | Elementary/Secondary (0-12)   | College (  | 1-4or 5+)                            | 1                                 | Accountan   |                               |  |                                    | Accoun                                | ting                      |                                 |
| D              | filed<br>I Hyg<br>other<br>ent,  | BeC              | 17. Father's Name (First, Middle,   | Last)  |                                      | <del></del>                       |   | 18. Mother                    | 's Name (f                                   | First, Middle, M                   | aiden Surname)                        |                           |                                 |
| Maryland       | lld be<br>fenta<br>rked<br>ric ev  | To B             | Bertrand  | М  | arsch                                |                                   |   | Mat                           | tilɗa  |                                    | Ra                                    | aile                      | У                               |
| ary            | 2 should be filed w<br>h and Mental Hygie<br>is marked other the<br>raumatic event, the  | _                | 19a. Informant's Name/Relations   | hip (Type. Print)                                    |                                      |                                   | ng Address (Street  |                               |  |                                    |                                       | ate, Zip                  | Code)                           |
| Σ              | and 2<br>ealth a<br>n 27 is  |                  | Patricia L. Fi  | nke-daugh  | ter                                  | 1340                              | 30 Blythe   | nia Ro                        | i., P  | hoenix,                            | MD 211                                | 131                       |                                 |
| ore            | of He  |                  | 20a. Method of Disposition 1   Burial 2 □ Cremation                           | 2 Demousi from                                       | 20b. F                               | Place of Dispo<br>cemetery, cren  | sition <i>(Name of</i><br>natory or other place<br>Me <b>m '</b> I Pa | e)                            | Dat  |                                    | 0c. Location - Ci                     |                           | •                               |
| Ĕ              | Pages<br>ment of<br>ant; If it   |                  | 4 □ Donation 5 □ Other (S   |  |                                      |                                   |   |                               | 5/29/  |                                    | Baltimo                               |                           |                                 |
| Baltimore,     | permit. Pages 1 and 2 should be<br>Department of Health and Menta<br>Important: If item 27 is marked<br>any Injury or other traumatic e<br>once.   |                  | 21. Signature of Emeral Service   | Licensee Will  | iam G.                               | Dau 22                            | 2. Name and Addre   |                               |  |                                    |                                       | . Но                      | me, Inc.                        |
|                |  |                  | 23a. Part 1. Enter the disease, or shock, or heart failure. List              | complications that                                   | caused the deat                      | h. Do not ent                     | er the mode of dyir   | ng, such as c                 | ardiac or r                                  | espiratory arre                    | st,                                   |                           | Approximate<br>Interval Between |
| Ú,             | Physician  |                  | Immediate Cause (Final disease or condition                                   | / one sauce on t                                     | Juoco                                | rdial                             | infa  | ce hier                       | 8  |                                    |                                       |                           | Onset and Death                 |
|                | /Medical   |                  | resulting in death)   | Due to   | (or a conseq                         |                                   | 17.17.00  | Cito                          | <u>.                                    </u> |                                    |                                       | _                         |                                 |
|                | Examiner   |                  | Sequentially list conditions,   | b  | Aspin                                | ation                             | pneu  | mon                           | C  |                                    |                                       |                           |                                 |
|                | ed<br>sit  | ine              | if any, leading to immediate cause. Enter Underlying                          | Due to   | (o. as a conseq                      | uence of):                        |   |                               |  |                                    |                                       |                           |                                 |
| )).            | and<br>-tran   | Examiner         | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last | C  | (or as a conseq                      | uence of):                        |   |                               |  |                                    |                                       | +                         |                                 |
| 8760,          | cate be executed<br>physician and<br>the burial-transit  |                  |   |  | (or uo a donooq                      | 301/00 017.                       |   |                               |  |                                    |                                       |                           |                                 |
| 287            |  | edical           |   | d  |                                      |                                   |   |                               |  |                                    |                                       | $\pm$                     |                                 |
| ROX            | eath certific<br>attending p<br>for use as   | Ž                | IF FEMALE:<br>23b. Was decedent pregnant                                      |  | tcome of pregna                      |                                   |   |                               |  |                                    | 23d. Date of                          | of delive                 | rv                              |
| ň              | death certif<br>e attending<br>d for use as  | Physician/Me     | in the past 12 months?<br>1 ☐ Yes 2 ☐ No                                      | 4 ☐ Preg   | birth 2☐ Feta<br>nant at time of o   |                                   | Ectopic pregnanc Other (specify)                                      | у                             |  |                                    | Month                                 |                           | Day Year                        |
| J.             | y th   | hys              | 9 Unknown   | 9 □ Unki   | nown                                 |                                   |   |                               |  |                                    |                                       |                           |                                 |
|                | s that<br>ined l   | by P             | Part II. Other significant condition  | ns contributing to d                                 | eath but not res                     | ulting in the ur                  | nderlying cause giv   | en in Part I.                 |  | 23e. Did toba                      | acco use contrib                      | ute to th                 | e cause of death?               |
| ğ              | w requires that the de<br>been signed by the<br>should be detached   | ed b             | ļ   |  |                                      |                                   |   |                               |  | 1 ☐ Yes                            | 2 □ No 3                              | ☐ Prob                    | ably 4 Unknown                  |
| ပ္က            | aw re  | plet             |   |  |                                      |                                   |   |                               |  | 24a. Was an                        |                                       | re autor                  | osy findings available          |
| Vital Records, | The law requires that<br>rate has been signed b<br>page 2 should be deta   | Completed        |   |  |                                      |                                   |   |                               |  | autopsy<br>perform<br>1 □ Yes 2    | ed? 🎤 l dea                           | or to con<br>ath?<br>]Yes | npletion of cause of            |
| <u>ta</u>      | i <b>lcian</b> ; The<br>certificate<br>ector, pag  | Be C             | 25. Was case referred to medical  |  |                                      |                                   |   | 26. Place                     | of Death (                                   | Check only one                     | · · · · · · · · · · · · · · · · · · · | 1103                      | 2 23110                         |
| 0              | Physician:<br>r this certifica<br>ral director, p  | 2                | examiner?<br>1 ☐ Yes 2 █ No   | Hospital:  | Inpatient 2                          | ER/Outpatier                      | it 3 □ DOA Oth  | er: 4 □ Nur                   | sing Home                                    | 5 🗆 Resider                        | nce 6 Other                           | (Specify                  | )                               |
| 0 0            | ding Phys<br>h.<br>After this<br>funeral di.   | Certification:   | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investig            | 1  | of Injury<br>oth, Day, Year)         | 28b. Time of<br>Injury            | Worl  | yat<br>⟨?<br>Yes 2 □ N        | - 1  | d. Describe hov                    | v injury occurred                     |                           |                                 |
| DIVISION       | Atten<br>deat<br>ctor:<br>y the  | fica             | 3 ☐ Suicide 6 ☐ Could r   | ot bo  | of Injury - At he                    | ome, farm, stre                   | eet, factory, office  |                               |  | . Location (Stre                   | eet and Number                        | or Rura                   | l Route Number.                 |
| 2              | al or /<br>s after<br>Il Dire  | erti             | 4 ☐ Homicide determ   | build  | ing, etc. <i>(Specit</i>             | <i>(y)</i>                        |   |                               |  | City or Town,                      | State)                                |                           |                                 |
|                | or the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,                            | edical C         | 29a. Certifier 1 Certifyin (Check only one)                                   | g Physician: To the<br>Examiner: On the b<br>and man | e best of my kno<br>basis of examina | owledge, death<br>ation and/or in | n occurred at the till<br>vestigation, in my o                        | me, date and<br>pinion, deatl | d place, an                                  | d due to the ca<br>at the time, da | use(s) and manr<br>te and place, and  | er as st                  | tated.<br>the cause(s)          |
|                | To the   | Me               | 29b. Signature and title of certifier   |  |                                      |                                   | 29c. Licens   | e number                      |  | 29                                 | d. Date signed (i                     | Month, I                  | Day, Year)                      |
|                |  |                  | 1/5/201   | 10-  | - MI                                 | 9                                 | n   | 617                           | 2,5  |                                    | 5176                                  | 10                        | 8                               |
|                | 17   |                  | 30. Name and address of person  | who completed cau                                    | se of death (Iten                    | n 23a) (Type,                     | Print)  | 011                           | <u>.</u>                                     |                                    | 5/26<br>- MD                          | , _                       |                                 |
|                | 12+1   |                  |   | on Mo  | 880                                  | 00 W                              | Wher  | Blud                          | I Pa   | arkville                           | e MD                                  | 21                        | 234                             |
|                | Sta  |                  | 31. Date filed (Month, Day, Year)   | 2. F   | Registrar's Signa                    | ture                              | 1. 1  |                               | /  |                                    | /                                     |                           | •                               |
|                | Registr  | ar               | MAY 2 9 2   | UUB JUGG   | HE SO.                               | PS TON                            |   |                               |  |                                    |                                       |                           |                                 |

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 9:27 a M 24 2008 Bernice Frances Margolet May 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4208 N. Charles Street Apt. Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) June 18,1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)

10f. Zip Code

1 ☐ Yes 2 ☐ No

16a. Decedent's Usual Occupation

Antique Dealer

4208 N.

20b. Place of Disposition (Name of cemetery, crematory or other place)

21218

1 □ M 2/□ F

Charles Street Apt.2

College (1-4or 5+)

Sister

86

10c. City, Town or Location

Baltimore

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify.

Minerva

Charles St. Apt2

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

(Give kind of work done during most of working life. DO NOT use retired)

Pennsylvania

10d. Inside City Limits

10g. Citizen of What Country?

Specify:

Wachstein

Balto.,

18. Mother's Name (First, Middle, Maiden Surname)

USA

16b. Kind of Business/Industry

Antiques

20c. Location - City or Town, State

23d. Date of delivery

Day

3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

2 No

Svile 200

14. Race - American Indian, Black, White, etc.

White

Md. 21218

Approximate Interval Between Onset and Death

Year

1050 York Road

1√Yes 2□No

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, II. "Involcal Examiner must be notified at 72 hours after Baltimore, Maryland 21215-0036 12 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r permit. Pages 1 and 2. Department of Health a Important; If Item 27 is any injury or other traionce.

**Physician** 

/Medical

Examiner

201-07-5110

Usual Residence of Decedent

Maryland

10e. Street and Number

4208 N.

1 X Never Married 2 ☐ Married

3 ☐ Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

20a. Method of Disposition

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

Louise Margolet /

10a, State

Director

Funeral

2

Completed

Be

၉

10h County

15. Decedent's Education (Specify only highest grade completed)

1 X Burial 2 ☐ Cremation 3 ☐ Removal from State

Margolet

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

POHE

2008

MD

Registrar's Signature

**Funeral** 

Director

**Physician** /Medical **Examiner** 

certificate be executed

P.O. Box 68760,

Division of Vital Records,

Examiner burial-trans attending physician for use as the buria Physician/Medical ed by the a detached fi signed by t I be detach \$ Completed has this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Certification: To

Lorraine Park ₩oodlawn, Maryland 5/30/08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furnity Service Liver see 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Md. 21204 ang 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Yulmonaxu disease or condition resulting in death) Due to (or as a consequeno Sequentially list conditions, it as a great grea Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 24a. Was an autopsy performed? Yes 2 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death

1 Natural

2 ☐ Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifier

State Registrar

1MO THY 31. Date filed (Month, Day, Year)

MAY 29

16755 Falls

Kood

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 10 /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RANK 8. Date of Birth (Month, Day, Year) **Funeral** Min 1 🗆 M Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show BAHIMON Yes 2 No M.D. **Funeral Director** 10g. Citizen of What Country? 10e. Street and Number 23a or pe 4.5, items ; 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married o. Specify: BALL 1 ☐ Yes 🎉 No þ **S** Widowed 4 □ Divorced 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CONTAINER COPP. Department of Health and Mental Hygiene, Important: If Item 27 is marked other than any Injury or other traumatic event, the Me once, Elementary/Secondary (0-12) College (1-4or 5+) MAChine OPERATO 8th gRAde NO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Tow 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 21. Signature of Fu ral Service Licenses 1129 N.CA BAITOMIN Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) DEMEN Physician /Medical Due to (or as a consequence of) SWD **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of) attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No autopsy 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manny of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locetion (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

after death. in by the

within 24 hours a the ို

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

2 9

🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Day, Year)

08

32 Registrar's Signa 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008

|   | -                 | For<br>State<br>Registrar  | State of Marylar  | Ce                       | rtificate of i                            | Death                  | R   | eg. No.                    | 008  | 1736                                     |
|---|-------------------|--|---|--------------------------|---|------------------------|---|----------------------------|--|--|
|   |                   | Decedent's Name (First, Middle, Last   | )   |                          |   |                        | 2. Date of Deat<br>Month                  | h<br>Day                   | Year   | 3. Time of Death                         |
| hysicia?<br>Medica/   |                   | JEANNETTE  | NELSON  |                          |   |                        | MAY                                       | 24,200                     | 2 8  | 2:20P M                                  |
| Examine   |                   | 4a. Facility Name (If not institution, give  |   |                          | 4b. City, Town, or                        |                        | th  | 4c. Count                  |  |  |
|   |                   | GILCHRIST HOSP:  5. Social Security Number   6. Sec |   | last hirthday            | TOWSON                                    | If Under 24 Hrs        | 8. Date of Birth                          |                            | TIMOR  | E (State or Foreig                       |
| uneral  | - 1               |  | M 2 □ F 54  | Yrs.                     | Months Days                               | Hours Min              |   | Year)                      | Country<br>C.  |  |
|   | - 1               | Usual Residence of Decedent  |   |                          |   |                        |   |                            |  | to day 0% 15-15                          |
| show  |                   | 10a. State 10b. County   | 10c. C  | ity, Town or Lo          |   |                        |   |                            | 100.   | . Inside City Limit<br>1 ☐ Yes 2 ☐ N     |
| r 28a-f show  | Director          | MD • N/A   |   | BAL'                     | TIMORE<br>10f. Zip Code                   |                        | 1   | Og. Citizen of             | What Country   |  |
| 3a or   | اق                | 326 PACA ST.   |   |                          | 212                                       | 201                    |   | USA                        |  |  |
| al", or Items 23a or<br>Evaninar must be  | Funeral           | 11. Marital Status   | 12. Was Decedent Ever in U<br>Armed Forces?                                     | J.S. 13.                 | Was Decedent of H<br>If Yes, specify Cuba |                        | Specify Yes or No-                        |                            | ce - American  |  |
| or Ite  | F                 | 1 Never Married 2 Married  | 1 Yes 2 No  |                          | 1 □Yes 2 □ No                             | Specify:               | to mean, etc./                            |                            |  |  |
| "natural", or Items<br>edical Evaminat m  | d by              | 3 Widowed 4 Divorced   | Year or Dates:  | 160 Door                 | dent's Usual Occup                        | ention                 | T   |                            | BUSINESS/Indus                                       |  |
| n "nat  | Completed         | 15. Decedent's Edu<br>(Specify only highest grad   | e completed)  | (Give                    | kind of work done                         | during most of wo      | orking                                    | TOD. KING OF E             | , de la 1635/11/200                                  | ou y                                     |
| grene   | E O               | Elementary/Secondary (0-12)  | College (1-4or 5+)  | DAY                      | CARE PRO                                  | VIDER                  |   | SELF                       | EMPLO  | YED                                      |
| d othe  | Be                | 17. Father's Name (First, Middle, Last)  |   |                          |   |                        | me (First, Middle, I                      |                            | me)  |  |
| Ment<br>arked<br>natic e  | 2                 | BUTLER NELSO   |   |                          |   |                        | A WRIGHT                                  |                            |  |  |
| h and   |                   | 19a. Informant's Name/Relationship (7) AMANDA NELSON   |   | 1                        | ng Address (Street  O Robins              |                        | Rural Route Numbel<br>Balto               |                            |  | ode)                                     |
| Healt<br>em 2   | ŀ                 | 20a. Method of Disposition   |   |                          | osition (Name of matory or other place    |                        |   |                            | - City or Towr                                       | n, State                                 |
| ent of<br>it: If it<br>y or o   |                   | 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify   |   |                          | matory or other place<br>DUNT CRE         |                        | May 27 08                                 | ר.דממ א                    | O MD   |  |
| Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic event, I'm Modical Ex once. | 1                 | 21. Signature of Funeral S-rvice Licens  | - 1   | 2                        | 2. Name and Addre                         | ss of Facility         |   |                            |  |  |
| B # F 8   |                   | 23a. Parl T. Enter the disease, or comp  | *   | T T                      | ALVIN B.                                  |                        |   |                            | 070  | 13                                       |
|   | Examiner          | disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a conse  Due to (or as a nor se  C.  Due to (or as a conse        | quence of):              | mcer                                      |                        |   |                            | 0  |  |
| the   | Physician/Medical | in the past 12 months?   | d   | tal death 3              | ☐ Ectopic pregnanc                        | ey .                   |   |                            | ate of delivery                                      | ay Year                                  |
| by the<br>tached  | ysic              | 1 □ Yes 2 XI/No<br>9 □ Unknown   | 9 Unknown   | death 3                  |   |                        |   |                            |  |  |
| igne<br>be o  | þ                 | Part II. Other significant conditions co   | ntributing to death but not re  | sulting in the u         | inderlying cause giv                      | en in Part I.          | 23e. Did to                               |                            | ntribute to the                                      | cause of death?                          |
| ate has   | Completed         |  |   |                          |   |                        | 24a. Was a<br>autops<br>perfor<br>1 □ Yes | sy                         | . Were autops<br>prior to comp<br>death?<br>1 □Yes 2 | y findings availal<br>pletion of cause o |
| certific<br>rector,   | Be                | 25. Was case referred to medical examiner?   | Hospital:   | 7.55/0.1                 | nt 3 🗆 DOA Oth                            | or:                    | eath (Check only on                       |                            |  | 10 000/0                                 |
| er this<br>eral di  | n:Tc              | 27. Manner of Death  | 28a. Date of Injury   | 28b. Time of             | III 3 LI DOA                              | 4 🗆 Nursing            | Home 5 ☐ Reside                           |                            | ther (Specify)<br>rred                               | MAPLE                                    |
| within 24 hours after death.  To the Funeral Director: After completely filled in by the funer.   | Certification: To | 1 Sentence   Sentence   2 Accident   Sentence   3 Suicide   Homicide   4 Homicide   Sentence   5 Pending investigation   6 Could not be determined   | (Month, Day, Year)  28e. Place of Injury - At building, etc. (Spec              | Injury<br>home, farm, st | M 1 🗆                                     | k?<br> Yes 2⊡No<br>——— | 28f. Location (S. City or Town            | treet and Num<br>n, State) | nber or Rural F                                      | Route Number,                            |
| n 24 hours<br>ne Funeral<br>sletely fille   | Medical C         |  | rsician: To the best of my kr<br>iner: On the basis of examinand manner stated. |                          |   |                        |   |                            |  |  |
| To the comp   | Mk                | 29b. Signature and title of certifier.   | ~ W>  |                          | 29c. Licens                               | 8303                   | 2   | 29d. Date sign             | ed (Month, Da  | la em                                    |
| 3   |                   | 30. Name and address of person who   | ompleted cause of death (Ite  | em 23a) (Type            | Print)                                    | Tows                   | un mo                                     | 21207                      | +  |  |

| ) po of the machine mik. Endarc An             | . Cobics VII of Pally V. |
|--|--------------------------|
| State of Maryland / Department of Health and M | ental Hygien 6 UUO       |

Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** MAY 26 3:40 a <sup>™</sup> 2008 <u>Virginia</u> Ε. Pack /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Future CARE Homewood Baltimore N/A 8. Date of Birth (Month, Day, Year) JUL 23 1920 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2 🗶 F 87 235-22-4711 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 28e-f show treumatic event, the Mudical Examiner must be notified at 1X Yes 2 No Director N/A Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code filed within 72 hours after death with ō 421 W. 24th Street 21211 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes. Give Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed by 3 ₩Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other than any injury or other treumatic event, If a Mones. Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pete Belldina Esther 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn L. Sullivan - daughter 421 W. 24th Street, Baltimore, MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Termation 3 Removal from State
4 Donation 5 Other (Specify) Metro Crematory, Inc. 5/28/2008 Baltimore, MD 21. Signature of Funeral Service Licensee

Steven H. Cremation Society of Maryland, Inc. Williams 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician esessovan /Medical Due to (or as a consequence of). Examiner Due to (or as a cons-of-ence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed burial-transit and Due to (or as a consequence of) Box 68760, Statu Post physician traculator Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy ó in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) P.O. I the 9 Unknown 9 Unknown à been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 1 Yes 2 No 3 Probably 4 Unknown maine Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy page performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physicien: 25. Was case referred to medical examiner?

1 
Yes 2 
No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 28a. Date of Injury (Month, Day Year) : After this funeral 27. Manner of Death 28c, Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Hatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: / 2 Accident 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 - Homicide filled To the Hospitel the Funerel 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 5/271 DZIY64 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. ENTAN ST ENT 30B BALTIMORE Hml 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 2 9 2008 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

|                     |   |                     | 1 - State of Maryland / De State of Maryland / C   | partment of He<br>ertificate of De                                    |  |   | ne<br>. No. 200                   | 8 17370  |
|---------------------|---|---------------------|--|---|--|---|-----------------------------------|--|
|                     | Physici   | ian                 | 1. Decedent's Name (First, Middle, Last)   |   |  | 2. Date of Death<br>Month                         | 28 28                             | 3. Time of Death   |
| -                   | /Medi   | cal                 | Tarulata Patel  4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Lo   |  | ay  | 4c. County of D                   | 10.3011  |
|                     | Examir  | ner                 | 10303 Balsamwood Court   | Laur  |  |   | ,                                 | George's   |
|                     | Funeral   |                     | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | y) If Under 1 Year   II   |  | B. Date of Birth                                  | 9.                                | Birthplace (State or Foreign Country)  |
|                     | Director  |                     | 187-50-5402 1□ M 21XF 53 Yrs   | Worth's Days  | Tiours Will.   | (Month, Day, Y<br>Aug 6, 1                        | 954                               | Kenya  |
|                     | land ow   |                     | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or   | Location  |  |   |                                   | 10d. Inside City Limits  |
|                     | Marylan<br>a-f show   | ģ                   | Maryland Prince George's Lau   | rel   |  |   |                                   | 1 ∐Yes 2 X No  |
|                     | or 28   | irec                | 10e. Street and Number   | 10f. Zip Code   |  | 10g   | . Citizen of What                 | t Country?   |
|                     | ath wi  | la l                | 10303 Balsamwood Court   | 2070  |  |   | United                            | States   |
| Maryland 21215-0036 | hours after death with the Maryland<br>tural", or items 23a or 28a-f show<br>at Exa ultrer must be notified at  | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:   | 3. Was Decedent of Hisp<br>If Yes, specify Cuban,<br>1 ☐ Yes 2 ሺ No S | anic Origin? (Spec<br>Mexican, Puerto R<br>Specify:            | ify Yes or No-<br>ican, etc.)                     | Black, W                          | American Indian,<br>Vhite, etc.<br>Asian–Indian                              |
| 5-0                 | 2 E E   | eted                | 15. Decedent's Education 16a. De (Specify only highest grade completed) (Gi  | cedent's Usual Occupation   | on<br>ina most of working                                      | 16  | b. Kind of Busine                 | ess/industry   |
| 121                 | vithin<br>ene.<br>than "  | Completed           | Elementary/Secondary (0-12) College (1-4or 5+)   | . DO NOT use retired)<br>Parent Liaso                                 |  |   | Scho                              | 01   |
| d 2                 | be filed within 72 ho<br>ital Hygiene.<br>id other than "natui<br>event, I're Medical   |                     | 17. Father's Name (First, Middle, Last)  |   | B. Mother's Name (   | First, Middle, Ma                                 |                                   |  |
| lan                 | Aental<br>Aental<br>rked c  | To Be               | Manubhai Patel   |   | Sharada  |   | Patel                             |  |
| lary                | ges 1 and 2 should be filed within 7 to Health and Mental Hygiene. If item 27 is marked other than "I or other traumatic event, Ite Men   | r                   |  | iling Address (Street and   |  |   |                                   |  |
|                     | and health  |                     |  | )3 Balsamwoo  |  |   |                                   | nd 20708   |
| Baltimore,          | nt of the filter  |                     | I LI Dunal 2 E+Cremation 3 Li Removal from State I   | position (Name of ematory or other place)                             | Da   |   | c. Location - City                | •  |
| Ë                   | artme<br>artme<br>ortant<br>injury  |                     | 4 □ Donation 5 □ Other (Specify) West Art  21. Sign fre of Funeral Service Licepees  | indel Cremat  |  |   |                                   |  |
| Ba                  | permit. Pages 1 and 2 s<br>Department of Health a<br>Important; If item 27 is<br>any injury or other trau<br>once.  | k j                 | Juanita R Thomas   | 22. Name and Address of Donaldson F<br>1411 Annapo                    | Funeral H<br>olis Road   | ome & Cr<br>Odento                                | rematory<br>on, Mary              | , P.A.<br>1and 21113   |
|                     |   |                     | 23a. Part 1. Ster the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.   | nter the mode of dying,   | such as cardiac or   | respiratory arrest                                | t,                                | Approximate<br>Interval Between  |
| - Comp              | Physician   |                     | Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Care as the condition of th | liovascular   | Disease  |   |                                   | Onset and Death<br>many years  |
| 4                   | /Medical<br>Examiner  |                     | Due to (or as a consequence of):   |   |  |   |                                   |  |
|                     |   | آو<br>ا             | Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury  |   |  |   |                                   |  |
|                     | cate be executed<br>physician and<br>the burial-transit   | Examiner            | triat initiated events   |   |  |   |                                   |  |
| ,<br>00             | oe exe<br>cian a<br>vurial-t  | Ĕ                   | resulting in death) Last Due to (or as a consequence of):  |   | ***  |   |                                   |  |
| 8760,               | icate be executed<br>physician and<br>s the burial-transit  | dical               | d  |   |  |   |                                   |  |
| P.O. Box 6          | Attending Physician: The law requires that the death certific roteath.  After After this certificate has been signed by the aftending p by the funeral director, page 2 should be detached for use as | Physician/Me        |  | ☐ Ectopic pregnancy<br>☐ Other (specify)                              |  |   | 23d. Date of<br>Month             | delivery<br>Day Year   |
| S, F                | ss tha<br>gned  |                     | Part II. Other significant conditions contributing to death but not resulting in the   | underlying cause given i  | in Part I.   | 23e. Did tobac                                    | **                                | te to the cause of death?  |
| ord                 | w requir<br>s been s<br>should I  | ted                 | Cerebro Vascular Disease   |   |  | 1 ☐ Yes   | 24 No 3□                          | Probably 4 Unknown   |
| al Records,         | yslcian: The law is certificate has b director, page 2 st   | Completed by        |  |   |  | 24a. Was an<br>autopsy<br>performe<br>1 □ Yes 2 2 | d? 24b. Were prior deat           | e autopsy findings available<br>to completion of cause of<br>h?<br>Yes 2 ANo |
| ξ                   | rsicial<br>s certi<br>lirecto   | Be c                | 25. Was case referred to medical examiner?  1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat   |   | <ol> <li>Place of Death (</li> <li>A □ Nursing Home</li> </ol> |   | - 0 TOH                           |  |
| o                   | iding Phys<br>th.<br>: After this<br>funeral di   | n:T                 | 27. Manner of Death 28a. Date of Injury 28b. Time  | of 28c. Injury at   | t 28   | d. Describe how                                   |                                   | Specify)   |
| ior                 | endin<br>sath.<br>or: Aff   | atio                | 1 Matural 5 Pending (Month, Day, Year) Injur<br>2 Accident investigation   |   | s 2 🗆 No   |   |                                   |  |
| Division of Vital   | I or Attendi<br>after death.<br>Director: A<br>I in by the fu   | Certification: To   | 3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)   | treet, factory, office  | 28   | f. Location (Stree<br>City or Town, S             | et and Number of<br>State)        | r Rural Route Number,  |
|                     | To the Hospital or Attenc<br>within 24 hours after death<br>To the Funeral Director:<br>completely filled in by the t   | Medical Ce          | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.   | ath occurred at the time, investigation, in my opini                  | date and place, ar<br>ion, death occurred                      | nd due to the cau                                 | se(s) and manne<br>and place, and | er as stated.<br>due to the cause(s)   |
|                     |   | M                   | 29b. Signature and title of certifier  | 29c. License nu   |  | 29d   | . Date signed (M<br>May 21,       |  |
|                     | 19  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Typ  |   | T  | f = === 1   | 20707                             |  |
|                     |   |                     | R.G. Bhojraj, M.D. 704 Gorman Ave  |   | Laurel, N  | naryland  | 20/0/                             |  |
|                     | Sta<br>Registr  |                     | MAY 2 9 2008   | de  |  |   |                                   |  |
|                     |   |                     |  |   |  |   |                                   |  |

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 8:15 A.M 2008 05 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOGPITAL BALTIMORE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1**M** 2□ F 250-22-7472 84 Director JUNE14,1923 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits m.D. BATTIMORE 1 Pres 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code iral", or Items 23a or 3 Examiner must be r NorThwood 21212 6227 11.5.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. Timed Forces?

1 □ Yes 2 □ No Alian y

If Yes, Give

Year or Dates: Wall 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: B/KeK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BeTh-STECK Elementary/Secondary (0-12) College (1-4or 5+) CRAn- OPERATOR NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Maryland å ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6257 NOThwood DR BATTE. MD. 21212 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify) 3 ☐ Removal from State 21. Signature of Funeral Service Licensee atricia 1129 N. CARDINOST BATTIMORE, OD. 21 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PNEUMONIA. disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner ALUTE RENAL FAILURE that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ANAEMIA IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♥ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed 2/Z No Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Inpatient ပ 1 🔲 Yes 2 ER/Outpatient 3 DOA 9 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: **Division** ( or Attending 1 Natural
2 Accident 5 Pending investigation (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral L NC certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES OUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Deep Sharma PGY-2. Samagitan Hospital 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 17372 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death May 27, **Physician** 2008 9:10 P M Bernice Teresa Robv /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 □ M **2K**XF 213-50-4332 60 Director Germany Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Nedical Ensister must be notified at Director MD Baltimore Parkton 1 □Yes 2 XNo 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 21120 18703 Middletown Road USA death \ by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. within 72 hours after 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical Reg. Nurse permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them Z7 is marked oth any injury or other traumeste 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stanislaw Plajzer Irena Grzesiak 19a. Informant's Name/Relationship (Type. Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18703 Middletown Road Parkton, MD 21120 Dr. Robert E. Roby, Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 5/31/2008 Gardens of Faith Baltimore.. Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Towson, Maryland 21234 Inc. 1050 York Road Ruck Towson Funeral Home, 23a. Part 1. Enter the disease, or complications that caused the lefth. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Due to (or as a consequence of) burial-1 Box 68760, physician certificate be Physician/Medical the attending philosophia IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown signed by t t be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas page 2 autopsy certificate 2 No Division of Vital 1 □Yes funeral director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\superstruct{\substraction}{\substraction}\) Nursing Home 1 Yes 2 ₹No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 ☐ Residence 6 ☐ Other (Specify) this To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 \( \text{Accident} \) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 025205 30. Name and address of person who completed cause of ceatl (Item 23a) (Type, Print) N. Charles St. Balto. Md 21208 BMC

State Registrar 31. Date filed (Month, Day, Year)

Registrar's Signature

|                     |   |                      | 1 - For State Registrar   | Otato or mi  |  | ertificate of   |   |   | Reg. No.                                       | 0 1131   |
|---------------------|---|----------------------|---|--|--|---|---|---|--|--|
|                     | Physic<br>/Medi   |                      | 1. Decedent's Name (First, Middle, L<br>Florence  | SCHOEN   |  |   |   | 2. Date of Dead May Manth 8             | _  | 3. Time of Death 1:00 P. M                         |
|                     | Exami   | ner                  | 4a. Facility Name (If not institution, gi<br>Brooke Grove Nur   | sing & Reha  |  | Sand  | or Location of Dea<br>y Spring          |   | 4c. County of De<br>Montgom                    |  |
|                     | Funeral<br>Director   |                      |   |  | e (In yrs. last birthda<br>88 Yrs.           | y) If Under 1 Year<br>Months Days                               |   |   | 7 7 9 N  | irthplace (State or Foreign<br>White Or K          |
|                     | yland<br>low<br>at  |                      | 10a. State 10b. County  |  | 10c. City, Town or I                         | ocation   |   |   |  | 10d. Inside City Limits                            |
|                     | e Mar<br>la-f sh<br>tified  | ctor                 | MD Montgom  | ery  | Sandy Spi                                    | ring  |   |   |  | 1 □ Yes 2 No                                       |
|                     | ath with th<br>23a or 28<br>ust be no   | ral Director         | 10e. Street and Number<br>18131 Slade Schoo   | 1 Rd. #123   | В  | 10f. Zip Code<br>208  | 60                                      |   | U.S. A.  | Country?   |
| 9036                | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. | Completed by Funeral | 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced                                   | 12. Was Decedent I Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:    | Ever in U.S. 13                              | . Was Decedent of<br>If Yes, specify Cut<br>1 ☐ Yes 2 ☐ No      |   | Specify Yes or No-<br>rto Rican, etc.)  | 1 1  | nerican Indian,<br>nite, etc.<br>White             |
| 5                   | n 72 h<br>"natu<br>edical   | lete                 | 15. Decedent's E<br>(Specify only highest gr  | ducation<br>ade completed)   | 16a. Dec                                     | edent's Usual Occu<br>re kind of work done<br>DO NOT use retire | pation<br>during most of we             | orking                                  | 16b. Kind of Busines                           | s/Industry   |
| 712                 | within jiene.   | шо                   | Elementary/Secondary (0-12)   | College (1-4or 5   |  | ecretary  | ea)                                     |   | Bank   |  |
| Maryland 21215-0036 | should be filed<br>nd Mental Hyg<br>marked othe<br>matic event,   | To Be C              | 17. Father's Name (First, Middle, Las   | urland   | <b>.</b>                                     |   | 18. Mother's Na                         | ime (First, Middle,<br>illian Ra        | Maiden Surname)<br>Ift                         |  |
| lary                | 2 short and N ls ma   |                      | 19a. Informant's Name/Relationship  |  |  |   |   |   | r, City or Town, State                         |  |
| e, Z                | 1 and<br>Health<br>em 27<br>ther tr   |                      | Barbara Goldman /   | daughter   | 8023<br>20b. Place of Disp                   |   | est Way,                                |   | burg, MD                                       |  |
| Baltimore,          | Eages thent of I tant: If Ite   |                      | 1 XBurial 2 □ Cremation 3 □<br>4 □ Donation 5 □ Other (Speci  | fy)  | Menorah (                                    | ematory or other pla<br>Gardens                                 | May                                     |   | 20c. Location - City of Ft. Laudo              | erdale, FL   |
| Ba                  | permil<br>Depar<br>Impor<br>any In  | ,                    | 21. Signature of Funer Sirvice ice  | 15h  | 2  | 54 Carrol   | 1 St.,                                  | NW, Wash                                | nington, D                                     | Funeral Home<br>C 20012                            |
|                     |   |                      | 23a. Part1. Enter the disease, or con shock, or heart failure. List only                                    | plications that caused<br>one cause on each lin                            | ie.  | nter the mode of dy   | ng, such as cardia                      | ac or respiratory ar                    | rest,  | Approximate<br>Interval Between<br>Onset and Death |
| 'n.                 | Physician /Medical  |                      | Immediate Cause (Final disease or condition resulting in death)   | a. Renal   | Failure a consequence of):                   |   |   |   |  | Onest and Death                                    |
|                     | Examiner  |                      |   | bue to (or as a  | a consequence oi).                           |   |   |   |  |  |
|                     | ed sit  | iner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a  | a consequence of):                           |   |   |   |  |  |
|                     | rtificate be executed<br>ng physician and<br>as the burial-transit  | Examiner             | that initiated events resulting in death) Last  | c<br>Due to (or as a   | a consequence of):                           |   | <u> </u>                                | · · · · · · · · · · · · · · · · · · ·   |  |  |
| 68760               | te be e<br>ysiciar<br>e buria   |                      |   | d  |  |   |   |   |  |  |
| 89                  | ntificat<br>ng phy<br>e as th   | Medical              | IF FEMALE:  |  |  |   | -                                       |   |  |  |
| P.O. Box            | The law requires that the death certificate be executed to has been signed by the attending physician and rage 2 should be detached for use as the burial-transit   | Physician/I          | 23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown                                    | 23c. If yes, outcome p<br>1 ☐ Live birth<br>4 ☐ Pregnant at<br>9 ☐ Unknown | 2 Fetal death 3                              | □Ectopic pregnand<br>□ Other (specify) _                        | у                                       |   | 23d. Date of d<br>Month                        | elivery<br>Day Year                                |
| Vital Records, P    | uires that<br>signed b  | ð                    | Part II. Other significant conditions of Heart Failur   | contributing to death bu   | t not resulting in the                       | underlying cause given  | en in Part I.                           |   |  | to the cause of death?                             |
| <u>ဂ</u>            | aw requires<br>s been sig   | Completed            | HTN   |  |  |   |   | 24a. Was a                              |  | autopsy findings available                         |
| ř                   |   | Com                  |   |  |  |   |   | autop:<br>perfor<br>1∐ Yes              | med? prior to<br>death?                        | completion of cause of                             |
| VII                 | Physician:<br>this certificanal director, I   | Be (                 | 25. Was case referred to medical examiner?  | Manadalı   |  |   |   | ath (Check only or                      |  |  |
| _                   | his h   | <u>۲</u>             | 1 Yes 2 No 27. Manner of Death  | Hospital: 1 Inpatier 28a. Date of Injury                                   | nt 2 ER/Outpatie                             |   | 4 LANursing I                           |   | ence 6 Other (Sp                               | ecify)   |
| 0                   | ndIng<br>th.<br>: After<br>e fune   | tion                 | 1 Natural 5 Pending 2 Accident investigation  | (Month, Day  | Year) Injury                                 | Wo  | ryat<br>rk?<br>Yes 2∐No                 | 280. Describe he                        | ow injury occurred                             |  |
| DIVISION            | al or Atte  | Certification:       | 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  | 28e. Place of inju-<br>building, etc.                                      | ry - At home, farm, si<br>. <i>(Specify)</i> |   |   | 28f. Location (Si<br>City or Town       | treet and Number or F<br>n, State)             | Bural Route Number,                                |
|                     | To the Hospital or Attending P within 24 hours after death.  To the Funeral Director: After t completely filled in by the funeral   | Medical C            | 29a. Certifier (Check only one)  1 ★ Certifying Pf 2 ★ Medical Example 1                                    | nysician: To the best o<br>niner: On the basis of<br>and manner stat       | examination and/or it                        | th occurred at the tinvestigation, in my                        | me, date and plac<br>opinion, death occ | e, and due to the curred at the time, c | ause(s) and manner a<br>late and place, and du | as stated.<br>ue to the cause(s)                   |
| <b>.</b>            | To th<br>withir<br>To th<br>comp  | Me                   | 29b. Signature and title of certifier   | Lagrun   |  | 29c. Licens<br>D3 9   | e number<br>9793                        | 2                                       | 9d. Date signed (Mor<br>May 8, 200             | th, Day, Year)                                     |
|                     | , -4  |                      | 30. Name and address of person who Christopher Mays   | completed cause of de  | ath (Item 23a) (Type<br>TI 1 Princ           | e <sup>rin</sup> Philip   | Dr., 01r                                | ney, MD 2                               | 0832   |  |
|                     | Sta   |                      | 31. Date filed (Month, Day, Year)   | 32. Pegistra   |  | eo.   |   |   |  |  |

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 18 17374

|  |                  | *   | Certifica                                       | te of i                 | Death  | Re                                    | g. No.                       | 00                                   | 1737  |
|--|------------------|---|---|-------------------------|--|---------------------------------------|------------------------------|--------------------------------------|---|
| Physicia<br>/Medic   | al               | 1. Decedent's Name (First, Middle, Last)  Flan Simko  |   |                         |  | 2. Date of Death<br>Month             | Day 2                        | Year<br>COS                          | 3. Time of Death  |
| Examin   | er               | 4a. Facility Name (If not institution, give street and number) 8800 Walther Blvd. Apt #4612   |   |                         | 4b. City, Town, or Loc<br>Park                 | ille                                  | Bal                          | y of Death<br>. timor                | re  |
| Funeral<br>Director  |                  | 5. Social Security Number 061-07-7870  Usual Residence of Decedent  6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. las  | Yrs. If Unde<br>Months                          | r 1 Year<br>Days        | Hours Min.                                     | 8. Date of Birth<br>)5-06-19          | (°C)                         | 9. Birthp<br>Penn                    | lace <i>(State or Foreigr</i><br>ISylvania                        |
| yland  |                  |   | Town or Location                                |                         |  |                                       |                              | 1                                    | 0d. Inside City Limits  |
| Mar<br>e-f st  | ţō               | Maryland Baltimore  | Parkv   | ille                    |  |                                       |                              |                                      | 1 ☐ Yes 2 ☒ No  |
| or 28  | ire.             | 10e. Street and Number  | 10f. Zip  |                         |  | 100                                   | g. Citizen of                |                                      | try?  |
| ath w  | ral              | 8800 Walther Blvd. Apt #4612  |   | 2123                    | 34   |                                       | U.S                          | S.A.                                 |   |
| fter dear hems   | Funeral Director | 11. Marital Status  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Never Married 2 □ Married  12. Was Decedent Ever in U,S. Armed Forces?  1 □ Yes 2 ☒ No | 13. Was Dece<br>If Yes, spe                     | dent of Hi<br>cify Cuba | ispanic Origin? (Spec<br>In, Mexican, Puerto P | ify Yes or No-<br>ican, etc.)         |                              | ce - Americ<br>ck, White,            |   |
| urs a  | ۾                | 3 ☒ Widowed 4 ☐ Divorced   If Yes, Give Year or Dates:  | 1 ☐ Yes   | 2 🕇 No                  | Specify:                                       |                                       | Specif                       | y:                                   | White   |
| 72 ho  | Completed        | 15. Decedent's Education (Specify only highest grade completed)   | 16a. Decedent's Usus                            | al Occupa               | ation<br>during most of working                | 16                                    | Sb. Kind of B                | usin <i>e</i> ss/Ind                 | lustry  |
| vithin ne.   | ם                |   |   |                         | )<br>)<br>)                                    | g                                     | 0.45                         | Home                                 |   |
| iled w<br>tygien<br>ther th  | ဒီ               | 8<br>17. Father's Name (First, Middle, Last)  | Homema  | ker                     |  |                                       |                              | Home                                 |   |
| tould be family and a second s | To Be            | Stephen Senkowicz   |   |                         | 18. Mother's Name                              | Kosteln                               | ick                          |                                      |   |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show any injury or other treumatic event, the Medical Examinating must be netified at once.   |                  | Mr. George Breschi - Attorney   | 409 Washi                                       | ngto                    |  | Towson,                               |                              |                                      |   |
| ages in the state or of or of  |                  | 20a. Method of Disposition 20b. Plac 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  | e of Disposition (Nan<br>etery, crematory or o  | ne of<br>ther place     | 9)   |                                       | c. Location -                | City or Tov                          | wn, State   |
| it. Pg   |                  |   | and Memor                                       |                         |  | 30/200                                | g N                          | 1aryla                               | and   |
| perm<br>Depa<br>Impol  | 1                | 21. Signature of Funeral Service Licensee   | 22. Name an                                     |                         |  |                                       | 5 Harf                       |                                      |   |
|  | 4                | 23a. Part1. Enter the disease or complications that caused the death. I shock, or heart failure. List only one cause on each line.                          |   |                         | Ruck, Inc                                      |                                       |                              | e, Mar                               | yland 212   |
| ending physician and ruse as the buriel-transit  |                  | <b>b</b> .  | a consequence of):                              | 14                      | ط الحدث  | <b>.</b>                              |                              |                                      |   |
| iaw requires that the death certificate be executed as been signed by the ettending physician and 2 should be detached for use as the buriel-transit indeferd by Physician Medical Example   | alciait/Medica   |   | a consequence of): g in the underlying ca       | ause giver              | n in Part I.                                   | 23b. Did toba                         | cco use cor                  | ntribute to                          | the cause of death?   |
| res that th<br>signed by<br>be detacl  |                  |   |   |                         |  | 1 ☐ Yee                               | 2□ No                        | 3 🗆 Probe                            | ably 4 Unknown  |
| : The law requires the cate has been signed page 2 should be completed by  |                  |   |   | •                       |  | 24a. Was en a<br>performed            | utopsy<br>1?                 | com                                  | e autopsy findings<br>lable prior to<br>pletion of cause<br>eath? |
| The la   |                  |   |   |                         |  | 1 ☐ Yes                               | 21 No                        | 10                                   | Yes 2□ No   |
| icien: The certificate rector, pag   | 3 2              | 5. Was case referred to medical examiner?   |   |                         | 26. Place of Death (6                          | Check only one)                       |                              |                                      |   |
| Physicien: this certific ral director,   | 2                |   | Outpatient 3 DO                                 |                         | 4 LI Nursing Home                              |                                       |                              |                                      |   |
| Ital or Attending P. Its efter death. The Director: After tilled in by the funera Certification:   | 2                | Natural 5 ☐ Pending (Month, Dey Year)   | D. Time of 28 Injury M                          | Work?                   |  | d. Describe how i                     | njury occurr                 | ed                                   |   |
| Attending or death. Actor: After by the fune fill cation   |                  | 3 Suicide 6 Could not be 28e Place of Injury - At home  |   |                         | es 2 No  | Location (Street                      | t and Numbe                  | or Or Purol I                        | Pouta Number  |
| s effer<br>od in b   |                  | 4 Homicide building, etc. (Specify)   | iami, stroet, ractory,                          | Onice                   | 201  | City or Town, S                       | tate)                        | or nurair                            | noute Number,   |
| To the Hospital or Attending Physicien: within 24 hours eiter death To the Funerel Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (  | 2                | 9a. Certifier (Check only one)  Certifying Physicien: To the best of my knowled, and manner stated.   | ge, death occurred a<br>and/or investigation, i | t the time<br>n my opir | , date and place, and<br>nion, death occurred  | due to the cause<br>at the time, date | e(s) and mer<br>and place, a | nner as stat<br>nd du <i>e</i> to th | ted.<br>ne cause(s)   |
| withir To the Comp   |                  | 9b. Signature and title of certifier  | 29c.  | License r               | number   | 29d.                                  | Date signed                  | (Month, De                           | ey, Year)   |
| 1  |                  | PRANA   | (MM)  | 1)                      | 124242   | - 1                                   | 127                          | 28                                   |   |
|  | 3/               | Name and address of person who completed cause of death (Item 23e   | (Type, Print)                                   | lth                     | in Blug  | lan                                   | Kul                          | le v                                 | Md 21234  |
| State  | 3                | 1. Date filed (Month, Day, Year) 32 Registrar's Signature   | 1   |                         |  |                                       |                              |                                      |   |
| Registrar  |                  | MAY 2 9 2008 Shave St.  | Gorales   |                         |  |                                       |                              |                                      |   |

State of Maryland / Department of Health and Mental Hygiene Kimberly Sausnock 2008 1. For State Certificate of Death Reg. No. Registrar

1. Oecedent's Name (First, Middle, Last) 2. Date of Oeath Physician/ Month **Medical Examiner** 1545 hrs May 25, 2008 Kimberly Ann Sausnock 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Oeath 4c. County of Death Franklin Square Hospital Rosedale **Baltimore County** 7. Age (In yrs. last birthday) 8. Oate of Birth (MM/OO/YYYYY) 9. Birthplace (State or 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** Months Oays Hours 9 608 untry) Director March 26, 219-96-5491 1 M 2X F 40 Usual Residence of Oecedent 10c. City, Town or Location 10d. Inside City Limits any 1 Yes 2 X No 28a-f show MD Baltimore items 23a or 28a-f shoust be notified at once. Essex death with the Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 1208 Bridge Crossing Road 21221 USA Funeral 13. Was Oecedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Black, 12. Was Oecedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 Never Married 2 Married Yes è White Widowed Oivorced f Yes, Give Yeer Yes 2 X No specify: Specify: marked other than "natural" à 15. Oecedent's Education (Specify only highest grade completed) 16a. Oecedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. OO NOT use retired) Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hou
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nat
injury or other traumatic event, the Nadizal Exa Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker own home 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Morris Be Alonna Hamer 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Morris / father 7905 Wallace Road Baltimore MD 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Burial 2 Cremation 3 Bayview Crematory 5/29/08 Baltimore MD 4 Donation 5 Other Specify 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signature of Funeral Service Licenses Connelly Funeral Home of Essex 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause or ach line Between Onset and /Medical Death a. Intracerebral Hemorrhage Immediate Cause (Final disease ⊏.xaminer or condition resulting in death) Due to (or as a consequence of): b. Cocaine Use Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. reate has been signed by the attending physician and page 2 should be detached for use as the burial - transit Physician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, 23d. Oate of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Oay Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 V Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Oid tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 Yes No 28a. Date of Injury (Month, Day,Year) FOUND: After 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Oeath Certification: Subject used cocaine FOLIND: 1 Natural 1 Yes 2 ✔ No Pending To the Funeral Director: completely filled in by the May 24, 2008 0340 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 6 Could not be Suicide or Town, State) 1612 Riverwood Road, Essex, MD determined (Specify) Single Family Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and more stated. 29d. Oate signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCME May 27, 2008 30. Name and address of person who completed cause of death (Item 23a) David Fowler M.D. Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) MAY 2 9 State 2008 Registrar

OHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Simpkins 12:15A M Gloria Meria 05/ 21/ 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 403 Hayworth Place Oxon Hill Prince Georges If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F 579-42-8411 77 Director 04/16/1931 Virginia Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 2 should be filed within 72 mounts 23 or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show 7 is marked other parts and 25a or 28a-f show 7 is marked of the parts and 25a or 28a-f show 7 is marked of the parts and 25a or 28a-f show 7 is marked other parts and 25a or 28a-f show 7 is marked of the parts and 25a or 28a-f show 7 is marked other parts and 25a or 25a o Yes 2□No Oxon Hill MD Prince Georges Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20745 403 Hayworth Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ☐ Never Married 2 ☐ Married Black Baltimore, Maryland 21215-0036 1 ☐Yes 2 XXNo Specify. 2 Specify: 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Private Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be 1 nent of Health and Mental Euphemia Coles Berkley George other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other tra once. 403 Hayworth Pl.Oxon Hill, MD 20745 Simpkins/Daughter Kendra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ PBurial 2 ☐ Cremation 3 ☐ Removal from State 05-27-08 | Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Ft.Lincoln Cem. 22. Name and Address of Facility RONALD TAYLOR II FUNERAL HM 21. Signature of Funeral Service Licensee 108 W. NORTH AVE., BALTIMORE, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or restir tory arrest, shock, or heart failure. List only one cause on each liny. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, signed by the attending physician I be detached for use as the burial pe Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) Ö 9 Unknown ۵ Part II. Other significant conditions contributing to beath but for resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Miknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 2 No certificate 2 12 No 1 ☐Yes funeral director, 25. Was case referred to dical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: After 1 ai or Attending F after death. I Director: After d in by the funera 1 Vietural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitai within 24 hours a To the Funeral E 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) d title of certifier 29b. Signature a

State Registrar

DHMH 17 Rev 1/200

Nasreen Kango, M.D. - 7610 Carroll Ave., Suite

31. Date filed (Month, Day, Year) 32 Registrar's Signature

1AY 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ature

20912

205 Takoma Park,

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 6:20A 2008 20. **Physician** MAY JOHN SHAW TOOLE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S ADELPHI HEARTLAND HEALTH CARE Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) 5. Social Security Number Days Hours **Funeral** Months 1**X** M 2□ F 1919 NC JAN 9, 89 Director 237-14-6400 Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location the Maryland 10a State 10h County works 1 X Yes 2 □ No 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20020 3725 Nash Street, SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Black, White, etc. within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No Specify Specify. Maryland 21215-0036 If Yes, Give Year or Dates: **Black** ģ 3 Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Completed 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) State Department Contract Officer 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 12 should be fi h and Mental H 7 is marked of Hattie Neal Henry Toole ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Hyattsville, MD Pages 1 and 2 nent of Health a ant: If Item 27 is 3609 Hamilton Street Barbara V. Hubbard/Daughter or other Baltimore, Date 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □Cremation 3 □Removal from State permit. Page Department o Important: If any Injury or 05-27-2008 Brentwood, MD Ft Lincoln Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home of MD 21. Signature of Funeral Service Line once, 20746 Suitland, MD 4308 Suitland Road Donald R. Gray Approximate Interval Between Onset and Death 23a. Part. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as onsequence of): /Medical Failur Stages Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Carpontino burlal-trai Due to (or as a consequence of) Box 68760, Physician/Medical 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? for 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 2 No 1□ Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 27 NO Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 1 Yes 2 No М 2 Accident Director: / 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide determined 4 Homicide within 24 hours an To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signatur 47867 of death (Item 23a) (Type, Print)
701 Randolph Rd # 216 Pockville MD 20852
istrar's Signature and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Physician 8:00 P M May 28, 2008 Dora Ethel Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Glen Burnie 7975 Crain Hwy. Unit 223 If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Days Hours 1 □ M 2 🛛 F 1906 Maryland Director 101 25, Nov. 214-20-1009 Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Ite Medical Examinating a ust be mutilled at 1 ☐ Yes 2 🛛 No Director Glen Burnie Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21061 7975 Crain Hwy. Unite 223 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. ò Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 72 d 2 should be filed within 7 th and Mental Hygiene.
7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Minnie Krause ပ Oscar Selters 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun once. Glen Burnie, MD 21061 Unit 223; 7975 Crain Hwy. Helen Simmons / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition June 2 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) 2008 Brooklyn, Maryland Cedar Hill Cemetery 21. Signature of Fundal Servi-22. Name and Address of Facility
Kirkley-Ruddick Funeral Home, P.A. Glen Burnie, MD 21061 421 Crain Hwy. SE; Approximate Interval Between Onset and Death 23a. Part 1. Saler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examine be executed that initiated events resulting in death) Last and Box 68760. Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) ned by the a ☐Yes 2 No o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 🛣 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an he law cate has page 2 s autopsy performed' 2 No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: al or Attending F safter death. I Director: After d in by the funera After 5 ☐ Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier May 29,2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 17 8021 Ritchie Hwy; Pasadena, MD 21122 MD Cyriac, Dr. Chackumkal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 'Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2018

|          |  |                  | 1 - State<br>Registrar  | Cer                    | rtificate of L  | Death                                      | F   | Reg. No. 2: 00 C                                | 11319  |
|----------|--|------------------|---|------------------------|---|--|---|---|--|
| ı        | Dhusisi  |                  | 1. Decedent's Name (First, Middle, Last)  |                        |   |  | 2. Date of Dea<br>Month                   | ath<br>Day Year                                 | 3. Time of Death                                 |
|          | Physici<br>/Medic  |                  | Cordelia Udenkwo  |                        |   |  | May 5                                     | 2008  | 4:47 a M   |
|          | Examin   |                  | 4a. Facility Name (If not institution, give street and number)  |                        | 4b. City, Town, or  | Location of Death                          |   | 4c. County of Dea                               | th   |
|          |  | 190              | Laurel Regional Hospital  |                        | Laurel  |  |   | Prince G  |  |
|          | Funeral<br>Director  |                  | 5. Social Security Number  212-55-5094  6. Sex 1 □ M 2 ★ F  | 72 Yrs.                | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs. Hours Min.                | 8. Date of Birt<br>(Month, Day<br>Aug. 10 | r, rear)  | thplace (State or Foreign ountry) geria          |
|          | jan  |                  | Usual Residence of Decedent   |                        |   |  |   | ,   |  |
|          | nylan<br>how<br>at   | ,                |   | ity, Town or Lo        | cation  |  |   |   | 10d. Inside City Limits                          |
|          | a-f sl   | cto              | Md. Prince Georges La   | anham                  |   |  |   |   | X□Yes 2□No                                       |
|          | or 28  | ire              | 10e. Street and Number  |                        | 10f. Zip Code   |  |   | 10g. Citizen of What Co                         | ountry?  |
|          | th wi  | ] E              | 7014 - 97th Avenue  |                        | 20706   |  |   | Nigeria   |  |
|          | ems  | Funeral Director | 11. Marital Status  12. Was Decedent Ever in Under Armed Forces?  | J.S. 13. V             | Was Decedent of Hi<br>f Yes, specify Cuba                         | spanic Origin? (Spen, Mexican, Puerto      | ecify Yes or No-<br>Rican, etc.)          | 14, Race - Ame<br>Black, Whi                    |  |
| 200      | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highty or other traumatic event; the Medical Examiner must be notified at ance.                                  | by               | 1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:  |                        | 1 ☐ Yes 2 ☐ No  | Specify:                                   |   | Specify: B                                      | lack   |
|          | 72 ho<br>natur<br>fical  | ed               | 15. Decedent's Education<br>(Specify only highest grade completed)  | 16a. Deced             | dent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | ation<br>Juring most of works              | ina                                       | 16b. Kind of Business                           | /Industry  |
| V        | ne.<br>han "ee Mec   | Completed        | Elementary/Secondary (0-12) College (1-4or 5+)  |                        | 00 NOT use retired,<br>usewife                                    | )  | 3   | Self-Emp  | loved  |
| V        | iled v<br>Jygie<br>Iher t<br>nt, th  |                  | 7th  17. Father's Name (First, Middle, Last)  |                        |   | 18. Mother's Name                          | (First, Middle,                           | Maiden Surname)                                 | 10,00  |
| <u> </u> | d be f   | Be C             | Duruaku Dim   |                        |   | Duruaka                                    |   | maraer, barname,                                |  |
| 5        | hould Me<br>mark<br>matic  | 욘                | 19a. Informant's Name/Relationship (Type. Print)  | 19b. Mailin            | ng Address (Street a  | and Number or Rura                         | al Route Numbe                            | er, City or Town, State,                        | Zin Code)  |
| 2        | d 2 s<br>Ith an<br>27 is<br>trau   |                  | Edwin Udenkwo (Son)   |                        | - 97th A  |  |   | Md. 20706                                       | • •  |
| ע        | 1 an<br>Heal<br>Hem 2  |                  |   |                        | sition (Name of matory or other place                             |  | Date                                      | 20c. Location - City or                         |  |
|          | ages<br>ent of<br>nt: If I   |                  | 1 M Burial 2   Cremation 3   Hemoval from State   |                        | natory or other plac<br>Cemetery                                  |  | 3/2008                                    | Okigwe, Ni                                      | geria  |
|          | artm. Portan   |                  | 21. Signature of Funeral Service Licensee   | 22                     | 2. Name and Addres  | s of Facility                              |   |   |  |
| ŏ        | permi<br>Depar<br>Impor<br>any ir  |                  | Wanda C. Bacon  | W.                     | . H. Baco<br>47 14th S  | n Funeral<br>Street. N                     | . Home,<br>.W. Wa                         | Inc.<br>shington, ]                             | D.C. 20010                                       |
| ŀ        | = = 7  |                  | 23a. Part1. Enter the disease, or complications that caused the dea<br>shock, or heart failure. List only one cause on each line.             |                        |   |  |   |   | Approximate<br>Interval Between                  |
|          | Physician  |                  | Immediate Cause (Final disease or condition Sepsis  |                        |   |  |   |   | Onset and Death                                  |
| À        | /Medical   |                  | resulting in death)  a. Due to (or as a conse   | quence of):            |   |  |   |   |  |
|          | Examiner   |                  | Sequentially list conditions b. Renal Fail  | ure                    |   |  |   |   |  |
| ,        | ₽ #  | iner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Metastatic                       | quence of):            |   |  |   |   |  |
|          | ecute<br>and<br>trans  | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last  C. Metastatic  Due to (or as a conse                                 |                        | al Cancer   | <u>c</u>                                   |   |   |  |
| 00/00    | ertificate be executed<br>ling physician and<br>e as the burial-transit  |                  | Due to (or as a conse   | quence on.             |   |  |   |   |  |
| 00       | physicate the  | Medical          | d   |                        |   |  |   |   |  |
| X        | certifi<br>iding<br>ise at   | -                | IF FEMALE: 23b Was decedent pregnent 23c. If yes, outcome pf pregi  | nancy                  |   |  |   | 23d. Date of de                                 | livery   |
| 0        | atter<br>atter<br>I for u  | ciar             | 23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No  23b. Was decedent pregnant in the past 12 months?  4 ☐ Pregnant at time of | tal death 3 □          | Ectopic pregnancy Other (specify)                                 |  |   | Month   | Day Year   |
| į        | the c<br>by the<br>ached   | Physician        | 9 ☐ Unknown 9 ☐ Unknown   |                        |   |  |   |   |  |
| ,        | s that<br>ned b  | by P             | Part II. Other significant conditions contributing to death but not re  | sulting in the ur      | nderlying cause give  | en in Part I.                              | 23e. Did to                               | obacco use contribute t                         | o the cause of death?                            |
| ecords,  | en sig   | edk              |   |                        |   |  | 101                                       | ∕es <u>≱</u> ∏ No 3∏ P                          | robably 4 Unknown                                |
| ב<br>כ   | law re<br>as be<br>2 sho   | Completed        |   |                        |   |  | 24a. Was                                  | an 24b. Were a                                  | utopsy findings available completion of cause of |
| ב        | The ate har page   | E O              |   |                        |   |  | perfo                                     | rmed? death?<br>2√2 No 1 □ Yes                  | _  |
| <u>a</u> | stiffic<br>ctor,   | Be (             | 25. Was case referred to medical examiner?  |                        |   | 26. Place of Deatl                         | (Check only o                             |   | <u> </u>   |
| -        | hysic<br>his co  | 은                |   | ☐ ER/Outpatien         |   | 4 Inursing Ho                              | me 5 Resid                                | dence 6 □Other (Spe                             | ecify)   |
|          | Ing P  |                  | 27. Manner of Death 28a. Date of Injury 1 X Natural 5 Pending (Month, Day Year)   | 28b. Time of<br>Injury | Work  |  | 28d. Describe I                           | now injury occurred                             |  |
| 2        | ttend<br>leath.<br>tor: /  | cati             | 2 Accident Investigation 3 Suicide 6 Could not be 289 Place of injury - At l  | homo form etc          |   | Yes 2 □ No                                 | Opt Langting //                           | Numer and Name to a Co                          | Desire North                                     |
| <u> </u> | lor A<br>after o<br>Direc  | Certification:   | 4 ☐ Homicide determined 28e. Place of injury - At building, etc. (Spec  | ify)                   | eet, factory, office  |  | City or Tox                               | Street and Number or Fi<br>n, State)            | urai Houle Number,                               |
|          | To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit | Medical C        | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my kr 2 Medical Examiner: On the basis of examiner and manner stated. | nowledge, death        | n occurred at the tin<br>vestigation, in my o                     | ne, date and place,<br>pinion, death occur | and due to the<br>red at the time,        | cause(s) and manner a<br>date and place, and du | s stated.<br>e to the cause(s)                   |
|          | To the   | Me               | 29b. Signature and title of contiflet   |                        | 29c. License  | number                                     |   | 29d. Date signed (Mon                           | th, Day, Year)                                   |
| ì        |  |                  | ////Javan   |                        | D648  | 74   |   | May 5, 20                                       | 08   |
| 1/2      |  |                  | 30. Name and address of person who completed cause of death (Ite Shahab Bavani, M.D. 1072   |                        | Print) S<br>le Patuxe   | Suite 200<br>nt Pkwy                       | С   | olumbia, Mo                                     | 1. 21044   |
|          | Sta<br>Registr   |                  | 31. Date filed (Marth Ray, Year) 2008 37 Registrar's Sign   | nature                 | este  |  |   |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-04098 State of Maryland / Department of Health and Mental Hygiene Leonard Wellsey Certificate of Death 1- For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day May 20, 2008 1530 hrs Medical Examiner 40n and 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore County** 806 Briar Hill Place Apt. H FSSEY If Under 1 Year If Under 24Hrs. 8, Date of Birth(MM/DD/YYYY) 9, Birthplace (State or Foreign, Mark Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Min. Country) Director 76 219-28-5276 Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 Yes 2 No s 23a or 28a-f show a within 72 hours after death with the Maryland Director 10f. Zip Code 10a. Citizen of What Country? 10e. Street and Numbe U.S. A 806 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 12, Was Decedent Ever in U.S. 11. Marital Status Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene.
Important: I filem 27 is marked other than "natural", or items; injury or other tranumatic event, the Medical Examiner must be a higher or other tranumatic event, the Medical Examiner must be a White, etc. Armed Forces? 1 Never Married 2 Yes Specify: Black Yes 2 No specify: If Yes, Give Year Divorced þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed College (1-4 or 5+) Elementary/Secondary (0-12) 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last rooms Joseph Be (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address Date 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place X Burial 2 Cremation 3 Removal from State Donation 5 Other Specify: Carlton Signature of Funeral Service Licenses 212 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. Death Medica a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease raminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical AMENDED UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE. Year 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an has been a prior to completion of cause of autopsy death? performed? Yes 2 V No Yes 2 No certificate 26.Place of Death (Check only one) 25. Was case referred to medical Be Other 4 Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 DOA Inpatient 2 ER/Outpatient 3 this 1 Yes No 28d. Describe how injury occurred 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death Certification: 1 🗸 Natural Yes 2 No within 24 hours after death.

To the Funeral Director: Director: Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be 3 or Town, State) (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier May 29, 2008 O.C.M.E.

5

Assistant Medical Examiner

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

31. Date filed (Month, Day, Year)

MAY 2 9 2008

111 Penn Street, Baltimore, MD 21201

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Frances Marie White 0 01 /Medical institution, give street and number) Examiner 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours Months 1 □ M 2 🗓 F 94 Yrs 0ct 212-07-6850 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Catonsville Director Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Department of Health and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2. any injury or other traumatic event, the Medical Example Once. 21228 USA 118 Forest Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify. Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant Food Warehouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John W. Roberts Laura Whitcomb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 118 Forest Avenue Catonsville, Maryland 21228 Jack Marlatt, Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 05/30/08 Lorraine Park Woodlawn, Maryland 21. Signature of Funeral Service Consee Thomas Gregor MacNabb Funeral Home, P.A. 301 Frederick Road Catonsville, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 57 0 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any cause in the list of cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical attending pl IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4□Pregnant at time of death 5 ☐ Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 ☐ Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. β 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No certificate Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 28 No 1 ☐ Yes 1 Inpatient 2. ER/Outpatient 3 □ DOA Certification: To within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

2008

|                   |  |                | For<br>State<br>Registrar  | State of Ma   | ryland / Depa<br><i>Ce</i>             | artment of H<br><i>rtificate of L</i>        |   | lental Hyg<br>R         | eg. No 2008                        | 3 17382                              |
|-------------------|--|----------------|--|---|--|--|---|-------------------------|------------------------------------|--------------------------------------|
| ţ.                | Dhygieir   |                | 1. Decedent's Name (First, Middle, L   | .ast)   |  |  |   | 2. Date of Dea<br>Month |                                    | 3. Time of Death                     |
| *                 | Physicia<br>/Medic   |                | MARK   | WHITH   | Ken                                    |  |   | may                     | 24 200                             | £ 2139 M                             |
|                   | Examin   | er             | 4a. Facility Name (If not institution, g   |   | contin                                 |  | Location of Death                       |                         | 4c. County of De                   | ath                                  |
| 2 44              |  |                | 5. Social Security Number 6.   | Sex 7. Age  | (In yrs. last birthday)                |  | If Under 24 Hrs.                        | 8. Date of Birth        | 9. B                               | rthplace (State or Foreign           |
|                   | Funeral<br>Director  |                | 214-92-0997  | 1 <b>X</b> M 2 □ F                                      | 46 Yrs.                                | Months Days                                  | Hours Min.                              | (Month, Day<br>January  | ; Yea <i>r)</i>                    | country) ryland                      |
|                   | D  |                | Usual Residence of Decedent  |   | 15 00 7                                |  |   | our wat y               | 70,130= 1120                       |                                      |
|                   | arylar<br>show<br>d at   | ř              | 10a. State 10b. County   |   | 10c. City, Town or Lo                  |  |   |                         |                                    | 10d. Inside City Limits 1 ☐ Yes 2 No |
|                   | he Ma<br>28a-f   | Director       | Maryland Baltin  | lore  | Durida                                 | 10f. Zip Code                                |   | 1                       | log. Citizen of What 0             |                                      |
|                   | with tag or 3  |                | 1725 Burnham Road  | ٦   |  | 212  | <b>ว</b> ว                              |                         | USA                                |                                      |
|                   | ms 23  | Funeral        | 11. Marital Status   | 12. Was Decedent E                                      | ver in U.S. 13.                        | Was Decedent of H If Yes, specify Cuba       |   | ecify Yes or No-        |                                    | nerican Indian,                      |
| 21215-0036        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | by             | 1 Never Married 2 Married 3 Widowed 4 Divorced   | Armed Forces?  1 ☐ Yes ② No If Yes, Give Year or Dates: | 0                                      | 1 ☐ Yes 2 ☐XNo                               |   | Hican, etc.)            |                                    | inte, etc.<br>Thite                  |
| <u>۾</u>          | 72 ho<br>natur<br>lical f  | Be Completed   | 15. Decedent's (Specify only highest of  | Education   | 16a. Dece                              | edent's Usual Occup                          | ation<br>during most of work            | ina                     | 16b. Kind of Busines               | s/Industry                           |
| 2                 | ithin he.  | nple           | Elementary/Secondary (0-12)  | College (1-4or 5+                                       | +)                                     | e kind of work done of<br>DO NOT use retired |   |                         | GI I                               |                                      |
| 2                 | led w<br>lygier<br>her th  | Ö              | 12 years 17. Father's Name (First, Middle, La  | ct)   | Sec                                    | urity Gua                                    |   | e (First Middle         | Steel Maiden Surname)              |                                      |
| anc               | the final Head of section of sect | Be c           | Orval Lee Whitake  |   |  |  |   | Jane Tho                | ŕ                                  |                                      |
| Maryland          | should Me Me mark  | ဥ              | 19a. Informant's Name/Relationship   |   | 19b. Maili                             | ing Address (Street                          |   |                         | r, City or Town, State             | , Zip Code)                          |
|                   | alth a<br>27 is<br>27 is   |                | Judith W. Sipe   | sister  | 1812                                   | : Ironwood                                   | Court We                                | est, Old                | lsmar, FL 3                        | 34677                                |
| altimore,         | of Her   |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3  | Domeyel from State                                      | 20b. Place of Disponentery, cre        | osition (Name of<br>ematory or other place   | ce)                                     | Date                    | 20c. Location - City               |                                      |
| <u><u>E</u></u>   | Page<br>ment<br>ant: II<br>ury o   |                | 4 □ Donation 5 □ Other (Spe.   |   |  | n Cemeter                                    | 1 -                                     | ,                       | Dundalk, M                         |                                      |
| Balt              | permit. Departr Imports any inj  |                | 21. Signature of the eral Service Lic  | Ch  | Č                                      | 2. Name and Addre<br>Connelly F<br>110 Solle | ss of Facility<br>Uneral Ho<br>rs Point | ome Of D<br>Road, D     | undalk,P. <i>l</i><br>undalk,Md.   | A.<br>21222                          |
|                   | -37  |                | 23a. Part 1 Enter the disease, or co   | omplications that caused                                | the death. Do not en                   |  |   |                         |                                    | Approximate<br>Interval Between      |
|                   | Physician  |                | Immediate Cause (Final disease or condition  | .,  | SEPSIS                                 | <  |   |                         |                                    | Onset and Death                      |
|                   | /Medical   |                | resulting in death)  | Due to (or as a   | consequence of):                       |  |   |                         |                                    | 1                                    |
| Е                 | Examiner   | _              | Sequentially list conditions,  | b   |  |  |   |                         |                                    | -                                    |
| 7                 | ed sit   | nine           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jiseas or Injury that initiated events | Due to (or as a   | a consequence of):                     |  |   |                         |                                    |                                      |
| 30                | ficate be executed<br>physician and<br>sthe burial-transit   | Examiner       | that initiated events<br>resulting in death) Last  | c<br>Due to (or as a                                    | a consequence of):                     |  |   |                         |                                    |                                      |
| 68760,            | siciar<br>siciar   | calE           |  | d   |  |  |   |                         |                                    |                                      |
| 89                |  | edical         | 11-11-11-11  |   |  |  | 3771                                    |                         |                                    |                                      |
| Box               | law requires that the death certifi<br>as been signed by the attending<br>2 should be detached for use as  | Physician/M    | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome p                                  |  | ☐Ectopic pregnancy                           | /                                       |                         | 23d. Date of o                     | delivery<br>Day Year                 |
| . E               | e dea<br>he att  | sicia          | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   | 4□Pregnant at<br>9□Unknown                              |  | Other (specify)                              |   |                         | Widitii                            | Day real                             |
| P.O.              | res that the de<br>signed by the a<br>be detached t  | Phy            | 9 ☐ Unknown  Part II. Other significant conditions   | s contributing to death bu                              | it not resulting in the i              | underlying cause giv                         | en in Part I                            | 23e. Did to             | obacco use contribute              | to the cause of death?               |
|                   | ires the signeral signeral   | by             | Part II. Other Significant conditions  | s contributing to death bu                              | a not recalling in the                 | andonying baddo giv                          |   |                         |                                    | Probably 4 Unknown                   |
| Š                 | w require<br>been siç<br>should b  | Completed      |  |   |  |  |   | 24a. Was a              | an 24h Were                        | autopsy findings available           |
| Re                | Ф <del>г</del> Ф   | mpl            |  |   |  |  |   | autop<br>perio          | nsy prior t<br>rmed? death         | o completion of cause of             |
| or Vital Records, |  |                | 25. Was case referred to medical   |   |  |  | 26. Place of Dea                        | th (Check only o        |                                    | es 2 No                              |
| <u> </u>          | Attending Physician:<br>r death.<br>ector: After this certifics<br>by the funeral director, p  | o Be           | examiner?<br>1 ☐ Yes 2 ☐ No  | Hospital:   | nt 2 ☐ ER/Outpatie                     | ent 3 DOA Oth                                | or.                                     |                         | dence 6 □Other (S                  | pecify)                              |
| 0                 | ng Ph<br>ter th  | n: T           | 27. Manner of Death  1 Natural 5 □ Pending   | 28a. Date of Injur<br>(Month, Day                       | y 28b. Time                            | of 28c. Injui<br>Wor                         | y at<br>k?                              | 28d. Describe h         | now injury occurred                |                                      |
| <u>S</u>          | endir  | atic           | 2 ☐ Accident investigat  |   |  |  | Yes 2 □ No                              |                         |                                    |                                      |
| Division          | or Att   | Certification: | 3 Suicide 6 Could not<br>4 Homicide determine  |   | iry - At home, farm, s<br>c. (Specify) | treet, factory, office                       |   | City or Tou             | Street and Number or<br>vn, State) | Rural Houte Number,                  |
|                   | pital<br>ours a<br>eral [  |                | 29a, Certifier 1 Certifying  | Physician: To the best of                               | of my knowledge, dea                   | ath occurred at the ti                       | me, date and place                      | , and due to the        | cause(s) and manner                | as stated.                           |
|                   | the Hospital<br>hin 24 hours a<br>the Funeral<br>npletely filled   | Medical        | (Check only 2 Medical Ex   | kaminer: On the basis of<br>and manner sta              | examination and/or i                   | investigation, in my                         | opinion, death occu                     | rred at the time,       | date and place, and                | lue to the cause(s)                  |
|                   | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fu   | Me             | 29b. Signature and title of certifier  |   |  | 29c. Licens                                  | e number                                |                         | 29d. Date signed (Mo               | onth, Day, Year)                     |
|                   |  |                | 1 Min  | 3   | n.D.Ph.                                | ). NE  | # -600                                  |                         | mm 7                               | 7, 2008                              |
| •                 | 1  |                | 30. Name and address of person w   | no completed cause of de                                | eath (Item 23a) (Type                  | e, Print)                                    |   | 2.0                     |                                    | 7, 2008-<br>i, mp 21224              |
|                   | \  |                | WEI JIANG  | 32 Bosister   | 40 EPS                                 | JANN A                                       | シンピルしき                                  | 12 M                    | aines                              | my was                               |
|                   | Sta<br>Regist  |                | 31. Date filed (Month, Day, Year)<br>MAY 2 9 2008  | ho completed cause of de                                | H. Sport                               |  |   |                         |                                    |                                      |

State of Maryland / Department of Health and Mental Hygiene 2998 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:30AM M May 23, 2008 Gloria L. Wiley /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Gilchrist Center f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 77 1931 Maryland Director 218-26-3952 May 19, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show If Item 27 is marked other than "natural", or Items 23a or 28a-f sho or other traumatic event, the Medical Examinating at MD Dundalk Baltimore Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 7503 Lawrence Road 21222 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2, No If Yes, Give A Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ۵ Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any Injury or other traumatic evany Injury or other traumatic ev White Piniecki Mabel George 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 Old Maple Court Baltimore, Maryland 21221 Mrs. Sandra Bauer/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State N Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht.of Jesus Cem. 5/27/08 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck F.H. of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** NON-SMALLCELL LUN CANCIA disease or condition resulting in deeth) MONTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical ned by the attending p detached for use as ' IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🗌 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □ Yes 1 ☐ Yes 2 🗆 No 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) #USPICE this 1 ∐Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To I Director: After this d in by the funeral c 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 10 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D64395 MAY 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEUE DOBERMANAND 6505 NOHAMISSI, SUITE 209 BALTIMONE, MA 21204

DHMH 17 Rev 1/2001

State Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:206 M NANCY C. WINSLOW (ble 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BLAKEHURST BALTIMORE TOWSON 8. Date of Birth (Month, Day, Year) 08/30/1914 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 💢 F 215-24-6039 93 Yrs. MARYLAND Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Expiritive I must be rufflind at ance. 1 ☐ Yes 2 XNo Director MD BALTIMORE TOWSON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1055 WEST JOPPA RD. 21204 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Completed by Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 4 Y R S HOUSEWIFE HOMEMAKER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be H. ARTHUR CANTWELL ANNE WHITE 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LAWRENCE BARRETT (NEPHEW) 23040 WILD HUNT DR. GAITHERSBERG, MD 20879. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State GREEN MOUNT 05/29/2008 BALTO CITY, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
HENRY W. JENKINS & SONS CO

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

| 그 트 등 리  |                        | Villet for   |  | YORK RD MON  |   |                                | 1   |
|--|------------------------|--|--|--|---|--------------------------------|---|
| ysician<br>Medical<br>aminer<br>e privilensit  | cal Examiner           | 23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | olications that caused the death. Do not enter the mode  | of duing such as cardiac or r                                  |   |                                | Approximate Interval Between Onset and Death MIMICA     |
| igned<br>be det  | d by Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Ho 9 □ Unknowh  Part II. Other significant conditions c   | 23c. If yes, outcome of pregnancy  1   | cify)  |   |                                | livery Day Year  the cause of death?  robably 4 Unknown |
| cate has beer<br>page 2 shoul  | Completed              |  |  |  | 24a. Was an autopsy performed?                    | death?                         | utopsy findings available completion of cause of        |
| ctor,  | Be                     | 25. Was case referred to medical examiner?   |  | 26. Place of Death (0  | Check only one)                                   |                                |   |
| his o  | ္                      | 1 ☐ Yes 2 ☑ No   | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA  | Other: 4 Nursing Home  | e 5 ☐ Residence 6                                 | ☐ Other (Spe                   | ecify)  |
| ath.   | ation:                 | 27. Manner of Death  1. Natural 5 ☐ Pending 2 ☐ Accident investigation   | (Month, Day, Year) Injury M  | c. Injury at Work? 1 □ Yes 2 □ No                              | d. Describe how injury                            | occurred                       |   |
| s after de<br>al Directo<br>ed in by t   | Certification:         | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)  | office 28f   | f. Location (Street and<br>City or Town, State)   | l Number or R                  | ural Route Number,                                      |
| n 24 noul<br>ne Funer:<br>pletely filli  | Medical (              | 29a. Certifier (Check only one)  Certifying Ph   | ysician: To the best of my knowledge, death occurred a niner: On the basis of examination and/or investigation, and manner stated. | t the time, date and place, an<br>n my opinion, death occurred | nd due to the cause(s)<br>d at the time, date and | and manner a<br>place, and due | s stated.<br>e to the cause(s)                          |
| To the complete of the complet | Ž                      | 29b. Signature and title of certifier  | 29c.   | License number 58303   | 29d. Date   | signed (Moni                   | th, Day, Year)<br>2008                                  |

DHMH 17 Rev 1/2001

State Registrar N. Charles

ST

70 WSON MD

21204

30. Name and address of person who completed cause of death (Item 23a) (Type Print)

32. Registrar's Signature

AMON J. CHAPLES M 6701

State of Maryland / Department of Health and Mental Hygienen 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. GIMOR 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** F (c) Months Days Hours 1 □ M 2 F 400-34-2150 Usual Residence of Decedent cb -18,1930 Director s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ☐ No M.D Funeral Director BAITIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2/2/3 4.5,A 14. Race - American Indian Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1□Yes 2□ Baltimore, Maryland 21215-0036 Specify BIALK Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drections 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be yex/Rude ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BA116. Teginald Willi 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 ☐Removal from State DANGELSTOWN MIT 5 ☐ Other (Specify) 21. Sign ture of Juneral Service Licensee J. MI 23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 40005 Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner requires that the death certificate be executed for use as the burial-tran and Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician d be detached for use as the buria IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes cate has been sig , page 2 should b 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No autopsy performed' certificate 1☐ Yes 2 4 NO Division or Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one director, Be Hospital: Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after deam.

To the Funeral Director: After this of normaletely filled in by the funeral director. Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Hospital 1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertified 30. Name and address of person se of death (Item 23a) (Type, Print) Raven Blud teat 31. Date filed (Month, Day, Year) State 2008 9 MAY 2 Registrar

| Cedric Yarborough,   | III 1- For State Registrar  | State of Maryland  | I / Department o<br>Certificate o |   | d Mental Hy                                   | giene<br>Req                                   | 2008  | 17386  |
|--|---|--|-----------------------------------|---|---|--|---|--|
| Physician/<br>Medical Examiner   | 1. Decedent's Name (Firs  | C M. YARBO   | ROUGH III                         |   |   | 2. Date of Death<br>Month I<br>May 25, 200     | Day Year<br>08  | 3. Time of Death<br>0056 hrs                     |
|  | 4a. Facility Name (if not in<br>Johns Hopkins F                                 | nstitution, give street and numbe<br>Hospital  | r)                                | 4b. City, Town, or L<br>Baltimore                       | Location of Death                             |  | 4c. County of Death                                       |  |
| Funeral<br>Director  | 5. Social Security Numbe <b>25 464</b> 214 <del>84 333</del>                    | 4  | nge (In yrs. last birthday)       | If Under 1 Year Months Days s.                          | If Under 24Hrs. Hours Min.                    |  | (MM/DD/YYYY) 9 Bir<br>Foreig<br>15,1989 <sup>Co</sup>     |  |
| Towany   | 3730 PIMO   | County   | 10c. City, Town or Local          |   | -   |  |   | 10d Inside City Limits 1 Yes 2 No                |
| ith the Maryland 23a or 28a-f show notified at once.   | 10e. Street and Number 3730 ELM   |  | DALLIF                            | 10f. Zip Code 212                                       | 13  | 10g  | Citizen of What Coul                                      |  |
| r death with the or items 23a compart be notif   | 11. Marital Status  1 X Never Married 2   | 12. Was Deceder  |                                   | as Decedent of Hisp<br>Yes, specify Cuban,              | panic Origin? ( Spe                           |  | USA<br>14. Race - Ameri<br>White, etc.                    | can Indian, Black,                               |
| rs after death ural", or itei miner must by Fune   | 3 Widowed 4   | Divorced If Yes Or Dates:  on (Specify only highest grade co   | 2 X No 1                          | Yes 2 No  | specify:                                      | ork done                                       | Specify: BLA  |  |
| MD 21215-0036  2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she market other than "natural" are items to notified at some To Be Completed by Funeral Director | Elementary/Secondary  |  | during r                          | most of working life.                                   |   |  | WELDING   |  |
| 215-0036 be filed within 7 had Hygiene rent, the Medica Be Comple  | 17. I ather a Hame (First,  | Middle, Last) M. YARBOROUGI  | H JR.                             | 1   |   | LL SUM   | MERVILLE  | CO.  |
| 무 등 등 등  | 19a Informant's Name/Ro   | UMMERVILLE(mo  | 1                                 | 30 ELMOR  | RA AVE.                                       | BALTO  | er, City or Town, State  MD 2121  20c. Location - City or | 3  |
| Baltimore,<br>permit. Pages I an<br>Department of He<br>Important: If ite  | 1 X Burial 2 Cr<br>4 Donation 5 C   | remation 3 Removal from Souther Specify:   | State crematory or o              | ther place)<br>E PARK                                   | MAY :   | 30,2008  | BALTO.C   | O.MD.  |
| Physician injury   | 21 Stature of Funeral  23a, Part I. Enter the dise                              | Service Licenses  Service Licenses | ed the death. Do not enter        | Name and Address ALVIN B. 412 F. F. Ithe mode of dving. | of Facility SCRUG( PRESTON such as cardiac or | GS FUNE  | ERAL HOME   | 21212<br>1 ate Interval                          |
| /Medical<br>Examiner   | failure. List only one<br>Immediate Cause (Final<br>or condition resulting in c | e cause on each line.<br><sub>disease a.</sub> Multiple Gunsl  | not Wounds                        | ,,  |   |  |   | Between Onset and<br>Death                       |
| iner   | Sequentially list condition if any, leading to immedia course. Enter Underlying | ate Due to (or as a con  | nsequence of):                    |   |   |  |   |  |
| executed an and all transit local Examiner   |   | itiated C.   | sequence of):                     |   |   |  |   |  |
| be exe   | UNPENDED  IF FEMALE:  | 23c. If yes, outc  | m/5.10a.b.perFome of pregnancy    | H.C879.5/29   | /08,WS  |  | 23d. Date of deliver                                      | ,  |
| cords, P.O. Box 68760 law requires that the death certificate be has been signed by the attending physical should be detached for use as the bunpleted by Physician/Me   | 1   | 4 Pregnant   | -14:                              | etal death 3 Other (Specify)                            | Ectopic pregnar                               | ncy  | Month [   | Day Year   |
| P.O. E es that the c signed by the be detached d by Phy  | `   | t conditions contributing to dea   | ath but not resulting in the      | underlying cause g                                      | iven in Part I.                               |  | acco use contribute to                                    |  |
| of Vital Records, P.O. Box 6876( sg Physician: The law requires that the death certificate ther this certificate has been signed by the attending physician director, page 2 should be detached for use as the bit To Be Completed by Physician/Me.            |   |  |                                   |   |   | 24a. Was ar<br>autopsy<br>perform<br>1 ✓ Yes 2 | y prior to death?   | utopsy findings available completion of cause of |
|  | 25 Was case referred to examiner?   | Hospital: 1 long   | tient 2 ER/Outpatier              |   | of Death (Check of Other Nursing              | nly one)                                       | tesidence 6 Othe  | r  |
|  | 27 Manner of Death  | 28a. Date of Ir<br>(Month. Da<br>May 25, 200   | njury 28b. Time of                |   |   | 28d. Describe ho<br>Subject was                | ow injury occurred shot                                   |  |
| Division of Vital   To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completely filled in by the funeral director.  Medical Certification: To Be C   | 2 Accident 3 Suicide 6 4 Homicide   | Could not be   | Injury - At home, farm, str       | eet, factory, office bi                                 |   |  | reet and Number or Ru<br>ate)<br>North Avenue, Baltin     | ral Route Number, City<br>nore, MD               |
| To the Hosp within 24 ho To the Func completely t  |   | fying Physician: To the best of cal Examiner: On the basis of example and manner state   | camination and/or investig        |   |   |  |   |  |
| F = 5   W  | 29b. Signature and title o  |  | /                                 | 29c. License<br>O.C.M                                   |   |  | 29d. Date signed (Mo<br>May 25, 2008                      | nth, Day,Year)                                   |
| 5  | Jack Titus MD.  | person who completed cause of<br>Deputy Chief Medical  | Examiner 111 Pe                   | enn Street, Balt  | imore, MD 212                                 | 201  |   |  |
| State<br>Registra  | 31 Date filed (Month, Da MAY 2  | 9 2008 2. Regist   | rar's Signature                   | 2   |   |  |   |  |
| DHMH 17 Rev 1/2001   |   |  | ORIGIN                            | AL  |   |  | OCHE  |  |

State of Maryland / Department of Health and Mental Hygien 2 1 1 8 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 5-10-2008 **Physician** 1006 A.M Anderson /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Prince George's Prince George's Hospital Cheverly If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Month Day 1 Year! 2 / 21 / 1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Days 072/20/6967 1 □ M 2 🔀 F Georgia Director 83 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 1 TXYes 2 □ No Director DC Washington DC 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? 703 M Street NW#203 20001 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Amed Forces? 11. Marital Status 14. Race - American Indian, Black White etc. hours after Yes 2X No f Yes, Give fear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black ፩ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Telephone Operator Private Industry 1 and 2 should be filed w Heelth and Mental Hygier tem 27 is marked other th 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Riley Anderson Wilhemina Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2::
Department of Heelth ar Important: If Item 27 is any injury or other treu 703 M Street NW#203 Washington DC 20001 Rodney Williams, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 

Burial 2 □ Cemation 3 □ Demoval from State
4 □ Donation 5 □ Other Specify Mt Zion Cemetery 5/21/2008 Baltimore, Md 21. Signature 22. Name and Address of Facility Taylors Funeral Home 1722 North Capitol St NW Wash DC 20001 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute Cardiopulmonary Arrest **Physician** /Medical Due to (or as a consequence of): Examiner Hypertensive Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed COPD Due to (or as a consequence of): attending physicien a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy certificate 1 ☐ Yes 2 X No 1 ☐ Yes 2 No director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ၉ After thi 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 28d. Describe how injury occurred 1 (XNatural Japita.
4 hours efter dec.
-rel Director: After 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 | Homicide To the Hospital within 24 hours e To the Funerel L Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier of death (Item 23a) (Type, Print) Central Ave. Landover umberbatch

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAY 1 5 2008

|                   |   |                  | For<br>State<br>Registrar   | State of Maryla   |                               | artment of h  |   |                                  | giene<br>Reg. No. <b>7</b> | 000   | 17200                               |
|-------------------|---|------------------|---|---|-------------------------------|---|---|----------------------------------|----------------------------|---|-------------------------------------|
| 14                | Physic  | ion              | 1. Decedent's Name (First, Middle, La   | ast)  |                               | -1  |   | 2. Date of De Month              | ath Day                    | 008<br>Year                                 | 3. Time of Death                    |
|                   | Physic<br>/Medi   |                  | Maxey Irby  | Abernathy   |                               |   |   | May                              | 12,                        | 2008  | 11:47a. <sup>™</sup>                |
|                   | Exami   | ner              | 4a. Facility Name (If not institution, gi   | ve street and number)   |                               |   | or Location of Death                                    |                                  |                            | unty of Death                               |                                     |
| - K.              |   |                  | Dove House  5. Social Security Number 6.  | Sex 7. Age (In v.   | rs. last birthday)            | West.   | minster  If Under 24 Hrs.                               | 8. Date of Birl                  |                            | roll  | lace (State or Foreign              |
| tin.              | Funeral<br>Director   |                  | 215-05-4844 Usual Residence of Decedent   | 1127 M 2□ F   | )2 Yrs.                       | Months Days   |   | (Month, Da<br>12/21              | y, Year)                   | Coun  | va                                  |
|                   | ylanc<br>how<br>at  |                  | 10a. State 10b. County  |   | City, Town or Lo              |   |   |                                  |                            | 1   | 0d. Inside City Limits              |
|                   | the Mar<br>r 28a-f sl<br>notified   | Funeral Director | MD Car<br>10e. Street and Number  | rroll   | Hamps                         | tead  10f. Zip Code                                       |   |                                  | 10g. Citizen               | of What Coun                                | 1 ☐ Yes 2 ☑ No                      |
|                   | h with  | a D              | 2411 Fairway Oal  | s Court   |                               |   | 21074   |                                  | USA                        | A   |                                     |
| 36                | is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at | by Funer         | 11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced                                  | 12. Was Decedent Ever in<br>Armed Forces?<br>1 ☐ Yes 2 ☑ No<br>If Yes, Give |                               | Was Decedent of H<br>If Yes, specify Cub<br>1 ☐ Yes 2☐ No | Hispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.)  |                            | Race - Americ<br>Black, White,<br>pecify: W |                                     |
| 9                 | hour<br>tural   | ed b             | 15. Decedent's E  | Year or Dates:  |                               | dent's Usual Occup  |   | -                                | 16b Kind                   | of Business/Inc                             |                                     |
| 21215-0036        | within 72<br>ene.<br><b>than "n</b> a<br><b>the Medic</b>   | Completed        | (Specify only highest gr  | ade completed)  College (1-4or 5+)  | (Give                         | kind of work done<br>DO NOT use retire                    | during most of work                                     | king                             |                            |   | tric Co                             |
|                   | Hygi<br>other<br>ent, t   | BeC              | 17. Father's Name (First, Middle, Las   | t)  |                               | *******   | 18. Mother's Nam  | e (First, Middle,                |                            |   |                                     |
| lan               | Aental rked c   | To B             | William Maxey Ab  | ernathy   |                               |   | Betty   | Jane Hu                          | dson                       |   |                                     |
| Maryland          | and 2 should be filed withir<br>ealth and Mental Hygiene.<br>n 27 is marked other than<br>ier traumatic event, the Ma   |                  | 19a. Informant's Name/Relationship<br>Hilda Abernathy   |   |                               |   | and Number or Rui                                       |                                  |                            | ,     | /                                   |
| altimore,         | Pages 1 and 3<br>ment of Health<br>ant: If item 27<br>ury or other tra  |                  | 20a. Method of Disposition  1 Burial 2 Cremation 3  | Removal from State  | cemetery, cre                 | osition (Name of<br>matory or other pla                   | ice)  | Date                             |                            | ion - City or To                            | ,                                   |
| Baltir            | permit. Pages 1 a Department of Hec Important: If item any Injury or othe   |                  | 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice   |   | 2741 2                        | 2. Name and Addre   | E   | line Fw                          | neral                      | Home  | •                                   |
|                   |   |                  | 23a. Part1. Enter the disease, or con   | nplications that caused the de  |                               |   | Main St. ng, such as cardiac                            |                                  |                            | Ma. 210                                     | Approximate                         |
|                   | Physician<br>/Medical   |                  | shock, or heart failure. List only<br>Immediate Cause (Final<br>disease or condition<br>resulting in death) | a. Dem  |                               | a   |   |                                  |                            |   | Interval Between<br>Onset and Death |
| 4                 | Examiner  |                  |   | Due to (or as a cons  |                               | idnes   | dia   | eme                              | Ki                         |   |                                     |
|                   | D ==  | ner              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (or as a cons  | equence or).                  |   | 1 0010  |                                  |                            |   |                                     |
|                   | ecuted<br>ind<br>transi   | Examiner         | Cause (Disease or injury that initiated events resulting in death) Last                                     | · Hype  | 1 ten                         | alun  |   |                                  |                            |   |                                     |
| 8760,             | cate be executed oblysician and the burial-transit  | dical Ex         | resulting in death) Last  | Due to (or as a cons  | equence of):                  | e Hee   | of the  | the                              | Q                          |   |                                     |
| .O. Box 68        | death certific<br>e attending p<br>d for use as   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                     | 23c. If yes, outcome pf preç 1 □ Live birth 2 □ F, 4 □ Pregnant at time o   | etal death 3                  | ⊒Ectopic pregnanc<br>⊒ Other <i>(specify)</i> _           | y   |                                  | 23d                        | . Date of delive<br>Month                   | ery<br>Day Year                     |
| <u>α</u>          | ires that t<br>signed by<br>I be detad  | by               | Part II. Other significant conditions   | contributing to death but not r   | esulting in the u             | nderlying cause giv                                       | ven in Part I.  | 23e. Did to                      |                            |   | ne cause of death?                  |
| or Vital Records, | The law requires that the te has been signed by the hage 2 should be detache  | Completed        |   |   |                               |   |   | 24a. Was                         | an 2                       | 4b. Were auto                               | psy findings available              |
| E H               |   | 9                |   |   |                               |   |   | perfo<br>1□ Yes                  | rmed?<br>2 A No            | death?                                      | 2 No                                |
| Vit               | iclan: Th<br>certificate<br>ector, pag  | Be               | 25. Was case referred to medical examiner?  | Hospital:   |                               | 011   | 26. Place of Deat                                       | h (Check only o                  | ne)                        |   | 3.1                                 |
| 0                 | Phys  | 은                | 1 ☐ Yes 2 ☐ No  27. Manner of Death   | 1 ☐ Inpatient 2 28a. Date of Injury   | ☐ ER/Outpatier<br>28b. Time o |   | 4 Li Nursing Ho   | ome 5 Residence 128d. Describe 1 |                            |   | " Hospice                           |
| Division          | Attending Physician: r death. ector: After this certific by the funeral director,   | Certification:   | Partial 5 ☐ Pending investigation 3 ☐ Suicide 6 ☐ Could not be  | (Month, Day Year)  Pe 28e. Place of injury - At                             | Injury home, farm, str        | M 1□  | rk?<br>]Yes 2 □ No                                      |                                  |                            |   | il Route Number,                    |
| ΟÌ                | spital or Attours after description of filled in by   | l Certi          | 4Hornicide  | building, etc. (Spe   |                               | h occurred at the ti                                      | me date and place                                       | City or Tov                      | vn, State)                 |   |                                     |
|                   | To the Hospital or At within 24 hours after d To the Funeral Direc completely filled in by  | Medical          | (Check only one)  2 Medical Exa   | miner: On the basis of exam<br>and manner stated.                           | ination and/or in             | vestigation, in my  | opinion, death occur                                    | rred at the time,                | date and pla               | ace, and due to                             | the cause(s)                        |
|                   | MIL   |                  | · aguns   | minotion  |                               | D.  | 51705   | 5                                | 51                         | 13 6  | 8                                   |
|                   | 6   |                  | 30. Name and address of person who  | completed cause of death (It  | em 23a) (Type,                | 2 mla   | DR, C   | Nestr                            | nins                       | ter ,                                       | MD 21157                            |

31. Date filed (Month, Day, Year) 32. Registrar's Signature MAY 1 3 2008 forte

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** George Thomas Albaugh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 □ F 62 212-42-8721 Oct 13, Pennsylvania 1945 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Westminster 1 ☐ Yes 2 No iral", or items 23a or 28a-f sh Examiner must be notified Maryland Carroll Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21158 2443 Mayberry Road Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2□No Viet 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: ģ white 3 ☐ Widowed 4 🏋 Divorced Nam Year or Dates: "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other traumatic event, the Medical r than Elementary/Secondary (0-12) College (1-4or 5+) s 1 and 2 should be filed within the Health and Mental Hygiene. Self Employed Pressure Washing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katherine Fleagle Harman G.M. Albaugh 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James A. Albaugh, brother 2443 Mayberry Road, Westminster, MD 21158 20b. Place of Disposition (Name of Scenerary, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Crematory 5/12/2008 Winfield, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home ·136 E. Baltimore St, Taneytown, MD 21787 Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock in heart failure. List only one cause or each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 2 /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-tran Due to (or as a consequence of): physician Records, P.O. Box 68760 Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 2□No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 ☐ Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29246 WJL

12+144

State

Registrar

31. Date filed (Month, Day, Year)

MAY

WASHINGTON HIE WESTMINSTER 224 32. Registrar's Signature

address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

|                |  |                     | 1 - For Amend Item 11 per State Amend Item 11 per Registrar  | State of Maryla<br>or FH mf 882 8/   | and / Depa<br>14/08 ek                       | artment o  | of Health a<br>of Death                              |                                | ntal Hygie                                    | ene<br>g. No. <b>2</b> ( | 008   | 17390  |
|----------------|--|---------------------|--|--|--|--|--|--------------------------------|---|--------------------------|---|--|
|                | Physici  |                     | 1. Decedent's Name (First, Middle, Last)  Robor +  |  | Acre-  | 0  |  | _                              | Month   | Day                      | 2008  | 10:30 AM   |
|                | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give s  | treet and number)  | 107  |  | vn, or Location of                                   | Death                          | 7   | 4c. Count                |   |  |
|                |  |                     | The Johns Hopkins Ho  5. Social Security Number 6. Sex   | -  | rs. last birthday)                           | Baltime<br>If Under 1                            | ore City   | 24 Hrs.   8.                   | Date of Birth                                 | Bal                      | timo  |  |
| ш              | Funeral<br>Director  |                     | 216-12-1412 <sup>1</sup> X   | M 2 □ F 86   | Yrs.   |  | Days Hours   | Min. 0                         | (Mooth, Day, Y<br>8 / 0 2 / 1                 | 921                      | Den   | ace (State or Foreign<br>y)<br>ton, MD             |
|                | show<br>show   | _                   | Usual Residence of Decedent  10a. State 10b. County  MD Caroline   |  | City, Town or Lo                             |  |  |                                |   |                          | 10  | 0d. Inside City Limits 1 ☐ Yes 2 ☐ No              |
| 2              | 28a-f  | recto               | 10e. Street and Number   |  |  | 10f. Zip-Co                                      | ode  |                                | 100   | g. Citizen of            | What Count                                      |  |
| 3              | 3a or  | al Di               | 305 Lincoln St   | reet   |  |  | 629  |                                |   | USA                      |   |  |
| 3e             | permit. Pages 1 and 2 should be lied within 72 hours after death with the maryland Department of Health and Mental Hygiene.  Important: If liem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funeral Director | 11. Marital Status  1 □ Never Married 2 ☑ Married  3 ☑ Wildowed 4 □ Divorced   | 12. Was Decedent Ever in Armed Forces?  1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Unk   |  | Was Deceden If Yes, specify  1 ☐ Yes 2 🎖         | t of Hispanic Orig<br>Cuban, Mexican,<br>No Specify: | gin? (Specify<br>, Puerto Rica | Yes or No-<br>an, etc.)                       |                          | ce - America<br>ack, White, e<br>ify:           |  |
| 215-0036       | in 72 nours<br>n "natural"<br>ledical Exa  | Completed b         | 15. Decedent's Edu<br>(Specify only highest grade  | cation   | 16a. Dece                                    | dent's Usual 0<br>kind of work o<br>DO NOT use r | done during most                                     | of working                     | 1   | 6b. Kind of I            |   |  |
| 212            | Hygiene.  Other than ent, the M  | Com                 | Elementary/Secondary (0-12)  | College (1-4 of 5+)  | Mec  | hanic  |  |                                |   |                          |   | pyard  |
| land           | ld be tile<br>ental Hy<br>ked oth<br>c event,  | To Be (             | 17. Father's Name (First, Middle, Last) Charles Acre   | ee   |  |  |  |                                | irst, Middle, M<br>Tilghi                     |                          | ime)  |  |
| Maryland       | and 2 should be n<br>eaith and Mental H<br>n 27 is marked ot<br>her traumatic ever   |                     | 19a. Informant's Name/Relationship (Type Sharon Acree  | pe. Print)   | 19b. Maili<br>867                            | ng Address (S<br>N. 43                           | rd St.   | er or Rural F<br>, Phil        | oute Number,<br>a., PA                        | City or Towr             |   | Code)  |
| 9              | Pages 1 and 2<br>nent of Health<br>ant: If item 27<br>ary or other tra   |                     | 20a. Method of Disposition 1 ☑ Bunal 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)  |  | b. Place of Dispo<br>cemetery, cre<br>estmin | matory or other                                  |  | Date<br>ery                    |   | oc. Location             |   | vn, State<br>PA 19004                              |
| Balti          | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.   |                     | 21. Signature of Funeral Service License   | O. Com   |  |  | Address of Facility Funeral                          |                                | e,P.O   | .Box                     | 2593  | 19805<br>,Wilm.,DI                                 |
|                | Physician /Medical Examiner pu   | Examiner            | 23a. Part 1. Enter the disease, of combinators, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to transcribe cause. Enter Underlying Cause (Disease or injury that initiated events | Due to for the control of the contro | sequence of):                                | no ch  | of dying, such as                                    | cardiac or r                   | espiratory arre                               | st,                      |   | Approximate Interval Between Onset and Death Dougs |
| D. Box 68760,  | Ine law requires that the death certilicate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit   | Physician/Medical E | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2   No   9   Unknown  | Due to (or as a const.  3. If yes, outcome of pre 1 Uive birth 2 I 4 Pregnant at time of 9 Unknown   | egnancy<br>Fetal death 3                     | □ Ectopic pre                                    |  |                                |   | - 1                      | ate of delive                                   | ery<br>Day <b>Y</b> ear                            |
| ds, P.O        | uires that tr<br>signed by<br>Id be detac  | by                  | Part II. Other significant conditions con  | ntributing to death but not  | resulting in the                             | underlying ca                                    | use given in Part                                    | l.                             | 23e. Did tob                                  |                          | ntribute to t                                   | he cause of death?                                 |
| Records,       | stetan: The law require<br>certificate has been sig<br>irector, page 2 should  | Completed           |  |  |  |  |  |                                | 24a. Was an<br>autopsy<br>perform<br>1  Yes 2 | · I                      | o. Were auto<br>prior to co<br>death?<br>1  Yes | psy findings available mpletion of cause of 2   No |
|                |  | Be (                | 25. Was case referred to medical examiner?   | Hospital:  |  |  | Other:   |                                | heck only one                                 |                          |   |  |
| jo             | ω D  | tion: To            | 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation  | 28a. Date of Injury<br>(Month, Day Year)   | 2 ER/Outpatie                                |  | 4 □ Nu<br>Injury at<br>Work?<br>1 □ Yes 2 □ I        | 280                            | 5 Resider                                     |                          |   | /)   |
| $\overline{a}$ | Io the Hospital or Attending Priving Within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral   | Certification:      | 3 Suicide 6 Could not be determined  | 28e. Place of injury - A building, etc. (Spe   |  | reet, factory, o                                 | ffice  | 28f                            | Location (Str<br>City or Town,                |                          | nber or Rura                                    | al Route Number,                                   |
|                | the Hospital of thin 24 hours a the Funeral Dimbletely filled in t | Medical C           | 29a. Certifier 1 Certifying Physical Certifying Chapter 2 Medical Exami  | sician: To the best of my ner: On the basis of examend manner stated.  | knowledge, deat<br>nination and/or in        | h occurred at<br>ovestigation, in                | the time, date an<br>my opinion, dea                 | nd place, and<br>ath occurred  | d due to the call at the time, da             | ause(s) and lace         | manner as se, and due t                         | stated.<br>to the cause(s)                         |
| ;              | vithin 2<br>To the<br>comple   | Me                  | 29b. Signature and title of certifier  |  |  |  | icense number  |                                | 29  | d. Date sign             | ned (Month,                                     | Day, Year)   |
|                |  |                     | Dan Celler   | MD   | )  | RE   | 55-0   | 00                             | /   | May_                     | 7, 2  | 800  |
| _              | 10   |                     | 30. Name and address of person who c   | A. MO  |  | , Print)   |  | 600 No                         | orth Wolf                                     | e St, B                  | altimo  | e, MD, 21287                                       |
|                | Sta<br>Regist  |                     | 31. Date filed (Month Day Year) 4 2  | 008 32. Redistrar's Signature  | gnature                                      | facility   | 7.   |                                |   |                          |   |  |

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 2008 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month > **Physician** Year 2000 M - UGENIA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 105 Woodlawn Avenue Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) Sep. 22,1956 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** New York Days Hours 1 M 2 F Months 121-50-4960 Yrs 51 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits r 28a-f show notified at MD Anne Arundel Annapolis 1 Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 Is marked other than "natural", or Items 23a or injury or other traumatic event, the Medical Examiner must be I 105 Woodlawn Avenue 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Mantal Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ite 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 2001-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 Widowed 4 Divorced 2008 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Navy Eiementary/Secondary (0-12) College (1-4or 5+) Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent John Montagnino Sophie Sonia Bunio 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 105 Woodlawn Avenue Annapolis, Maryland 21401 Josef Aponte/son 20b. Place of Disposition (Name of cemetery, crematory or other place Naval Academy Date 20a. Method of Disposition 20c. Location - City or Town, State Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Annapolis, Maryland Cemetery 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 21. Signature of Funeral Service Lice Party Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ylan /Medical

Examiner

the death certificate be executed

physician and the burial-tran

as attending properties of the second se

signed by

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed autopsy performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Month

1 ☐ Yes

Day

24b. Were autopsy findings available prior to completion of cause of death?

2 No

Year

Division or Vital Records, P.O. Box 68760, this certificate has been the Hospital or Attending Physician: nin 24 hours after death. completely filled in by the funeral director, Director: After 124 hours at To the

| SHIGH   |    |
|---------|----|
| Sta     | te |
| Registr | ar |

DHMH 17 Rev 1/2001

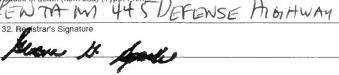
31. Date filed (Month, Day, Year) MAY 1 3 2008

29a. Certifier

(Check only

29b. Signature and title of certified

Medical



and manner stated.

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

10f. Zip Code 20010 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify.

Brown

Takoma

Housekeeping

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Days

Park

Hours

Specify: Black 16b. Kind of Business/Industry

Hotel Industry

14. Race - American Indian,

Black, White, etc.

2008

4c. County of Death

10g. Citizen of What Country?

USA

Montgomery

1241P

Birthplace (State or Foreign Country)

10d. Inside City Limits

1X Yes 2 □ No

Georgia

Reg. No. 7

2. Date of Death

8. Date of Birth (Month, Day, Year) 8/19/1936

Month

17. Father's Name (First, Middle, Last)

Elementary/Secondary (0-12)

18. Mother's Name (First, Middle, Maiden Surname) Aslean Patterson

Wright Jenkins 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Secify) 21. Signature of F

Ione Jones, Daughter

701불 7th St NW#101 Washington DC 20001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 5-14-08 Brentwood, Md Ft Lincoln

College (1-4or 5+)

Funeral Home 22. Name and Address of Facility Taylors 1722 North Capital St NW Wash DC 20001

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

**Physician** /Medical Examiner

attending physician and for use as the burial-transft

detached for

s been signed by to should be detach

certificate has

After this

Director:

within 24 hours a

To the Hospital or Attending Physician:

the funeral director, page 2:

the

Division or Vital Records, P.O. Box 68760.

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any Injury or other traum once.

Be

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Examiner

Physician/Medical

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Be Completed

2

Certification:

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final disease or condition resulting in death)

Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🔀 No

9 Hlnknown

If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 4□Pregnant at time of death

9□Unknown

3 ☐ Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

Day

24a. Was an autopsy performed? (es 21/21-No 1□ Yes 26. Place of Death (Check only one

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

25. Was case referred to medical examiner? 2 NO 1 Tes 27. Manher of Death 1 Natural

5 ☐ Pending investigation 2 Accident 6 Could not be determined

1 Impatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

3 DOA

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

3□ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year,

State Registrar

31. Date filed (Month, Day, MAY 1 5 2008

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 2, 2008 5:00 рΜ W. Breisch 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 14508 High Meadow Way North Potomac Montgomery . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) May 29, 1927 9. Birthplace (State or Foreign Months Days Hours 1 🔀 M 2 🗆 F 80 Country) IIIinois 359-20-0655 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland North Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14508 High Meadow Way 20878 USA 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. rmed Forces? ☑Yes 2☐No WWII 1 Never Married 2 Married 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: Specify Specify: White 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Priest Episcopal Church 5+ 17. Father's Name (First, Middle, Last) Dewey Breisch 18. Mother's Name (First, Middle, Maiden Surname)

Ft. Lincoln Crematory 5/12/2008

22. Name and Address of Facility

Unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14508 High Meadow Way, North Potomac, MD 20878

Date

1040 Rockville Pike, Rockville, MD 20852

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year)

1, 2008

Approximate Interval Between Onset and Death

2 years

4 years

Brentwood, MD

Simple Tribute

Physician /Medical Examiner

1 - For State Registrar

Jav

10a State

Director

Funeral

à

Completed

Be

ပ

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Flune at Service Licensee

20a. Method of Disposition

23a. Part 1. Enter he diseas shock, or hart failure.

Immediate Cau (Final disease or condition resulting in death)

Mr. Doug Breisch - Son

1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State

**Physician** 

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any ling or other traumatic event, Its Medical Eventure, must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

burial-trar attending physician for use as the buria ed by the a signed by t certificate has been s rector, page 2 should funeral director,

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and filled in by the

| Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                   | Due to (or as a consequence of).  c. Coronary Artery Disease  Due to (or as a consequence of):  d.  | 8 years   |  |  |  |  |  |  |
|---|---|---|--|--|--|--|--|--|
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 23c. If yes, outcome of pregnancy  1  Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)  9 Unknown | 23d. Date of delivery<br>Month Day Year                     |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute I  1 ★ Yes 2 No 3 F |   |   |  |  |  |  |  |  |
|   | peri  | s an prior to completion of cause of death? 2至No 1□Yes 2至No |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?  | 26. Place of Death (Check only  |   |  |  |  |  |  |  |
| 1 ☐ Yes 2 🖾 No  | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Res   | sidence 6 Other (Specify)                                   |  |  |  |  |  |  |
| 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Injury (Month, Day, Year)  28b. Time of Injury  Work?  1 □ Yes 2 □ No  | how injury occurred   |  |  |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not b<br>4 ☐ Homicide determined  | 28e. Place of Injury - At home, farm, street, factory, office 28f. Location   | (Street and Number or Rural Route Number,<br>wn, State)     |  |  |  |  |  |  |

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1830 Easy Monument Street Site 9020 Baltimore Marylano 21287

20b. Place of Disposition (Name of cemetery, crematory or other place)

complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.

Congestive Heart Failure; Diastolic

Due to (or as a consequence of)

Medical Doctor

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Obstructive Lung Disease

DHMH 17 Rev 1/2001

State Registrar

|   |  |  | For   | State of                                  | Marylan                                    |                       | artment of H                              |                                   | d Mental H                               | Hygie   | ne                         |         |  |
|---|--|--|---|---|--|-----------------------|---|-----------------------------------|--|---|----------------------------|---------|--|
|   |  |  | 1 - State Registrar Certificate of Death Reg. No. 2 1   |   |  |                       |   |                                   |  | No. 200                                       | Ω                          | 17391   |  |
| F   | 1. Decedent's Name (First, Middle, Last)  2. Date of Month  Name (First, Middle, Last)   |  |   |   |  |                       | Day Year                                  |                                   | 3. Time of Team                          |   |                            |         |  |
|   | /Medic   | al   | Kathleen Marga  |   | rning                                      |                       | 4b. City, Town, o                         | - Location of F                   | May 1                                    | 13,   | 4c. County of De           | nath    | 4:15A <sup>M</sup>                                 |
|   | Examin   | er   | 4a. Facility Name (If not institution, give Wilson Health Car   |   |  |                       |   | ersburg                           |  |   | Montgom                    |         | 7  |
| -   | Funeral  |  | Social Security Number 6. S | 2x 7.                                     | Age (In yrs.                               | last birthday)        | If Under 1 Year                           | If Under 24                       | Hrs 8 Date of                            | Birth   | 0.5                        |         | ace (State or Foreign                              |
| ı.  | Director   |  | 2/2-20-3336   | □M 2 <b>∏</b> F                           | 87   | Yrs.                  | Months Days                               | Hours                             | Min. (Month, Oct.)                       | 7,1   | 920 C                      | ana     |  |
|   | and w  |  | Usual Residence of Decedent  10a. State 10b. County   |   | 10c. Cit                                   | y, Town or Lo         | cation                                    |                                   |  |   |                            | 10      | Od. Inside City Limits                             |
|   | Maryli<br>f sho  | tor  | Maryland Montgome   | rv  | Gai  | thersb                | urg                                       |                                   |  |   |                            |         | 1√Yes 2□No   |
|   | r 28a  | Director   | 10e. Street and Number  |   |  |                       | 10f. Zip Code                             |                                   |  | 10g.  | . Citizen of What          | Count   | ry?  |
|   | th with  | al D   | 415 Russell Avenu   | ie #917                                   |  |                       | 208                                       | 377                               |  | U:  | nited St                   | ate     | s  |
|   | tems<br>er mi  | Funeral  | 11. Marital Status  | 12. Was Decedo<br>Armed Forc              | es?  | S. 13.                | Was Decedent of H<br>If Yes, specify Cuba | lispanic Origin<br>an, Mexican, F | ? (Specify Yes or<br>Puerto Rican, etc.) | r No-   | 14. Race - Al<br>Black, W  |         |  |
| 36  | rs afte  | by F   | 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  | 1 ☐ Yes 2<br>If Yes, Give<br>Year or Date |  |                       | 1 ☐ Yes 2🌠 No                             | Specify:                          |  |   | Specify: W                 | nit     | e  |
| 9   | 2 hou  | ted  | 15. Decedent's Ed   | ucation                                   |  | 16a. Dece             | dent's Usual Occup                        | ation                             |  | 16  | b. Kind of Busine          | ss/Ind  | ustry  |
| 215   | thin 7:<br>e.<br>an "n<br>Medi   | ple  | (Specify only highest gra   | College (1-4                              | lor 5+)                                    |                       | kind of work done<br>DO NOT use retired   | during most of<br>d)              | t working                                |   |                            |         |  |
| 2   | ed wil<br>ygien<br><b>her th</b>   | Completed  |   | 5+  |  | Hom                   | emaker                                    |                                   |  |   | Own                        | Hon     | ıe   |
| and   | be fil<br>ntal H<br>ed oth   | Be   | 17. Father's Name (First, Middle, Last)  John Ades  |   |  |                       |   |                                   | Name (First, Mid<br>h Green              | idie, Ma                                      | iden Surname)              |         |  |
| 2   | 2 should be filed within 72 hours after death with the Maryland nand Mental Hygiene.<br>Is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notifiled at   | 2  | 19a. Informant's Name/Relationship (7   | vne Print)                                |  | 19h Mailir            | ng Address (Street                        |                                   |  | ımber. C                                      | ity or Town State          | e Zin   | Code)  |
| <u>8</u>  | nd 2 s<br>Ilth an<br>27 is i   |  | Warren W. Berning   |   | band                                       |                       | Russell A                                 |                                   |  |   | -                          |         |  |
| ē,  | othe   |  | 20a. Method of Disposition  |   | 20b. F                                     | Place of Dispo        | sition (Name of<br>matory or other place  |                                   | lay 13,                                  |   | c. Location - City         |         |  |
| Ē   | Page Timent  | -  | 1 ☐ Burial 2 ②ACremation 3 ☐ 4 ☐ Donation 5 ☐ Other ( <i>Specif</i> y   |   |  |                       | tan Crema                                 |                                   | 2008                                     | A1  | exandria                   | , V     | a.   |
| Baltimore, Maryland 21215-0036  | permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.   |  | 21. Signature of Funeral Service Licen  | see                                       |  |                       | 2. Name and Addre                         |                                   |  |   |                            |         |  |
| ш   | <u>6 % 5 7 9</u>   |  | · Cuelis C  | . Cou                                     |  |                       |   |                                   |  |   |                            | g,      | MD. 20877  |
| ŝ   |  |  | 23a. Part1. Enter the disease, or comp<br>shock, or heart failure. List only<br>Immediate Cause (Final  | one cause on each                         | ch line.                                   | n. Do not ent         | er the mode of dylr                       | ng, such as ca                    | irdiac or respirato                      | ry arrest                                     | 1                          |         | Approximate<br>Interval Between<br>Onset and Death |
|   | Physician /Medical   |  | disease or condition resulting in death)  | a   | emer<br>as a conseq                        |                       |   |                                   |  |   |                            | 4       | LESLZ  |
|   | Examiner   |  |   | Due to (of                                | as a conseq                                | derice or).           |   |                                   |  |   |                            |         | ,  |
| II.   | ं य  | Jer  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | Due to (or                                | r as a conseq                              | uence of):            |   |                                   |  | -   |                            |         |  |
|   | scuted<br>nd<br>transit  | Due to (or as a consequence of):  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  |   |   |  |                       |   |                                   |  |   |                            |         |  |
| 8760,   | Due to (or as a consequence of):    Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death) Last   Consequence of injury that initiated events resulting in death   Consequence of injury that initiated events resulting in death   Consequence of injury that initiated events resulting in death   Consequence of injury that initiated events resulting in death   Consequence of injury that initiated events re |  |   |   |  |                       |   |                                   |  |   |                            |         |  |
|   | cate b   | dical  | •   | d   |  |                       |   |                                   |  |   |                            | +-      |  |
| 9 X C   | death certifice<br>attending ph<br>I for use as t  | /Me  | IF FEMALE:  |   |  |                       |   |                                   |  |   | 23d. Date of               | delive  | rv   |
| . Box   | death<br>e atter<br>d for u  | IF FEMALE: 23b. Was decedent pregnant in the past 12 profits? 1   Yes 2   No 9   Unknown   9   Unknown   23c. If yes, outcome pf pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month   23d. Date of delive   Month   Mont |   |   |  |                       |   |                                   |  | Day Year                                      |                            |         |  |
| 0.  | at the<br>by the   | hys  | 9 Unknown   | 9∐Unknow                                  | vn   |                       |   |                                   |  |   |                            |         |  |
|   |  |  |   |   |  |                       |   |                                   |  |   |                            |         |  |
| 1   Yes 2   No 3   P  |  |  |   |   |  |                       |   |                                   |  |   |                            |         |  |
| Zec   | elaw<br>hasb   | Completed  |   |   |  |                       |   |                                   | a  | Vas an<br>autopsy<br>performe                 | 24b. Were prior death      | to cor  | osy findings available<br>npletion of cause of     |
| a   |  |  | OF Western died   |   |  |                       |   |                                   | 1  Y                                     | es 2  | No 1 🖺                     | es/es   | 2 □ No   |
|   | rsicial<br>s certii<br>lirecto   | o Be   | 25. Was case referred to medical examiner?  1 Yes 2 No  | Hospital:                                 | patient 2                                  | ER/Outpatier          | nt 3 DOA Oth                              | er:                               | f Death <i>(Check oi</i><br>ing Home 5□F |   | oo 6 DOthor /9             | Spooifi | 4  |
| סׁ  | g Phys<br>er this<br>eral dii  | n: To  | 27. Manner of Death   | 28a. Date of                              | Injury                                     | 28b. Time o           |   |                                   |  |   | injury occurred            | pecity  | 1  |
| Solution of Death Solution of |  |  |   |   |  |                       |   |                                   |  |   |                            |         |  |
| <u>\( \) \( \) \( \) \( \) \( \)</u>  | or Atterderinecte  | tific  | 3 ☐ Suicide 6 ☐ Could not be determined   | 200. Flace 0                              | f injury - At ho<br>g, etc. <i>(Specii</i> | ome, farm, str<br>fy) | eet, factory, office                      |                                   | 28f. Location<br>City of                 | on <i>(Stree</i><br>r Town, S                 | et and Number of<br>State) | r Rura  | I Route Number,                                    |
|   | 25. Was case referred to medical examiner?    25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Many fer of Death   28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at Work?   27. Many fer of Death   28d. Describe how injury occurred   28d. Describe ho |  |   |   |  |                       |   | × 00 04                           | anto d                                   |   |                            |         |  |
|   |  |  |   |   |  |                       |   |                                   |  |   |                            |         |  |
|   | ro the vithin ro the comple  | Med  | 29b. Signature and title of certifier   | \ /                                       | -  |                       | 29c. Licens                               | se number                         |  | 290   | . Date signed (M           | onth,   | Day, Year)   |
|   | 12   |  | · nt.   | ) ohn                                     | 4  |                       | 0. 2                                      | 20149                             | 8  | 1   | 1ay 13                     | -       | 2008   |
|   | 100  |  | 30. Name and address of person who  | sompleted cause                           | of death (Iter                             | n 23a) (Type,         | Print) Avenu                              | je Gi                             | athersbu                                 | <u>, , , , , , , , , , , , , , , , , , , </u> | Maryl                      | an c    | 1  |
| 4   | Sta<br>Registr   |  | 31. Date filed (Month, Day, Year)   |   | jistrar's Signa                            | ature                 | boules                                    |                                   |  | J   |                            |         |  |
|   | riegisti   |  |   |   | -40-0                                      | //                    |   |                                   |  |   |                            |         |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. N2 8 0 8 1- State Registrar Amend #25, perME, 9880 6/9/08 TT Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Month Πav **Physician** Brown James APRIL 30 2008 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SALIS BURY
If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. PENINSULa Kleyonal Med. Wicomico CENTER 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**M** M 2□ F 261-74-7172 25-1943 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examiner must be notified at once. 10h. County 1 Yes 2 No Wicomico Eden Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Walnut Tree 218 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify 10 ck 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Crown Cork and Seal lachine perator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Brown Marie H mter ည 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 26210 Walnut Tree Rd. Eden MD Callie Brown 31833 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Spring Hill Memory Garders 5-6-2008 Hebron 4 ☐ Donation 5 ☐ Other (Specify) sonal lie st. uneral Service 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Funeral Homes Salisbury, MD 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Hypoxic & ENCEPHALOPATHY disease or condition resulting in death) /Medical Examiner Sequentially list conditions, in the land cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner CERTIFICATION APPROVED BY MEDICAL EXAMINER The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) المركبير المركبير المركبير المركبير المركبير المركبير Division or Vital Records, P.O. Box 68760, ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Alcoholism 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Desorder 24a. Was an perforn within 24 hours after death.

To the Funeral Director: After this certificate to completely filled in by the funeral director, page 1∐ Yes 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 To the Hospital or within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5-1-08 129105

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHRISTSON HUDDUSTON M.D. 100 E. Carroll St.

31. Date filed (Month, Day, Year) MAY 13 2008

State

Registrar

Solisbury, Ud.

Amended Item 1 per Phy. 05/12/2008 Carroll Co., wjl & Item 7 per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene F.D. For State Registrar Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Physician JOSEPH S. BARAN 4:54 P M 2008 MAY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Carroll Hospital Center 7. Age (In yrs. last birthday) If Under 1 8. Date of Birth (Month, Day, Year) Year If Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Months Days MP untry) 12M 2□F 218-26-3761 77 Yrs. 5/16/3 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more or 28a-f show once. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Wostminster 1 ☐ Yes 2 No MD Director Carroll 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21158 3630 Halter R US by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces 1 Never Married 2 Married ZYes 2 No Yes, Give 1 If Yes, Give 1950 - 53 white 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Communication Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Baren Mary Barr Steven ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3630 Halter Rd.Westminster, MD 21158 Josephine Baran-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition St. Mary's Cemetery 5/13/08 Silver Run, MD
22. Name and Address of Facility
17 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 17340 21. Signature of Funeral Service Licenses Little's FH 34 Maple Ave.Littlestown, PA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) coronary aftery disease **Physician** 5years /Medical Due to (or as a consequence of): Examiner >10 45 Type 2 Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner > 20 4/5 The law requires that the death certificate be executed It y pertension the attending physician and ned for use as the burial-tran Due to (or as a consequence of): >1043 or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 ☐ Unknown this certificate has been signed by a director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 10 Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After (Month, Day Year) 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide 💌 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0051778 16 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) 8047 Balkware MS JADI B SEGAL MA 1830 E. MONUMENT ST. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Cheeve It sports Registrar 2008

Division or Vital Records, P.O. Box 68760.

State Registrar

31. Date filed (Month 1 3 2008 egistrar's Signature

use of death (item 23a) (Type, Print)

M

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 5:30 PM 2008 Eva Brewer /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice Randallstown 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1949 Director 58 231 84 1337 Aug 29, Israel Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evaniner must be notified at Director 1 ☐ Yes 2√☐ No MD Columbia Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, Ite Medical Examinations and injury or other traumatic event, Ite Medical Examinations 11106 Cricket Hollow Court 21044 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 Mar No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. δ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Alex Kessler Johanna unknown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Brewer/Husband 11106 Cricket Hollow Court Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Ardent Cremation 5-13-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 olles 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a TERMINAL OVARIAN CARCINOMA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or se a consequance of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) P.0. the detached 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 W No 2 **PNo** 1 □ Yes 1 □ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certified director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) SEASONS 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Natural HOSPICE 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 ☐ Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 145931 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (5) REISTONSTOWN MD 25 MAIN 31. Date filed (Month, Day, Year) gistrar's Signature State 14 2008 Registrar

|  |                  | _1             | For<br>State<br>Registrar  | State   | or iviaryial  |                                  | rtificate of I   |                                    |   | Reg. No. 2                    | 008  |   |
|--|------------------|----------------|--|---|---|----------------------------------|--|------------------------------------|---|-------------------------------|--|---|
|  | /sicia<br>ledica | n              | 1. Decedent's Name (First, Midd<br>Susan S.  | Byler   |   |                                  |  |                                    | 2. Date of Dea<br>May 20,                 |                               | Year   | 3. Time of Death 1:00 P M                                   |
|  | amine            |                | 4a. Facility Name (If not institution 9830 N. Rycevi   |   | number)   |                                  | 4b. City, Town, or <b>Mech</b> a   | Location of Dec<br>nicsvil         |   | 4c. Count                     | of Death  Char                               | _   |
| Fund   | · ·              |                | 5. Social Security Number <b>216–82–1269</b>   | 6. Sex<br>1 ☐ M 2 <b>X</b> F                      | 7. Age (In yrs  | s. <i>last birthday)</i><br>Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hi<br>Hours Mi         |   | y, Year)                      | Cou  | place (State or Foreign<br>ntry)<br>s <b>ylvania</b>        |
| aryland<br>show  | ed at            |                | Usual Residence of Decedent  10a. State 10b. County  |   | 10c. C  | city, Town or Lo                 |  | anicsvi                            | 11.                                       |                               |  | 10d. Inside City Limits 1 ∐Yes 2X No                        |
| with the M   | be notifie       | Director       | 10e. Street and Number   | arles   | <u>;</u>  |                                  | 10f. Zip Code  | .0659                              |   | 10g. Citizen of What Country? |  |   |
| ire, IMBLYIBLIO ZIZIO-UUOO<br>s 1 and 2 should be filed within 72 hours after death with the Maryland<br>if Health and Mental Hygiene.<br>Item 27 is marked other than "natural", or Items 23a or 28a-f show | Examiner mus     | by Funeral     | 9830 N. Rycevi  11. Marital Status  1 Never Married 2 Ma  3 XWidowed 4 Divorce   | 12. Was De Armed                                  | ecedent Ever in U<br>Forces?<br>s 2 <b>X</b> No<br>Give<br>Dates: | 1                                | Was Decedent of H<br>If Yes, specify Cuba<br>1 ☐ Yes 25 No               | ispanic Origin?<br>an, Mexican, Pu | (Specify Yes or No-<br>erto Rican, etc.)  | - 14. Ra<br>Bla<br>Spec       | ace - Ameri<br>ack, White,<br>ify: <b>Wh</b> |   |
| vithin 72 ho   | e Medical        | Completed      | 15. Decede<br>(Specify only high<br>Elementary/Secondary (0-12)  | nt's Education<br>est grade completed<br>College  | d)<br>(1-4or 5+)  | (Give                            | dent's Usual Occup<br>kind of work done<br>DO NOT use retired<br>memaker | ation<br>during most of w          | vorking                                   | 16b. Kind of I                | Business/Ir<br>Own H                         | -   |
| 2 should be filed vand Mental Hygie is marked other t  | c event, th      | To Be Co       | 17. Father's Name (First, Middle  John Stoltzft  |   |   | lio lio                          | alcina KCI   | 18. Mother's N                     | lame (First, Middle,<br>Hannah            | Maiden Surna                  | ıme)   |   |
| INICAL Should alth and M 27 is mar   | er traumat       | -              | 19a. Informant's Name/Relation  Benjamin Z. By   |   | n   |                                  | ng Address (Street Rycevil   |                                    | Rural Route Numbe                         | er, City or Town              |  |   |
| parmit. Pages 1 and 2 Department of Health a Important: If Item 27 is  | ury or othe      |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (   |   | m State W   | odhurn                           | osition (Name of<br>matory or other place<br><b>Hill</b>                 | inay                               | Date 23,                                  | 20c. Location                 |  | own, State<br>11e,Marylan                                   |
| partit. Departit   | any ini          |                | 21. Signature of Funeral Service   | Kh  | rdin  | en 2                             | 2. Name and Addre<br>Matting1<br>P.O. Box                                | ss of Facility<br>ey-Gard<br>270   | iner Fune<br>Leonardto                    | eral Ho<br>own, MD            | me P<br>2065                                 | o <sup>A</sup> .  |
| Physic<br>// /Medi   | ical             |                | 23a. Part1. Enter the disease, shock, or heart failure. Lis<br>Immediate Cause (Final disease or condition resulting in death)                             | st only one cause or                              | t caused the dea<br>n each line.<br>to (or as a conse             | ERS                              | ter the mode of dyir   | 2.01                               | diac or respiratory a                     | rrest,                        |  | Approximate<br>Interval Between<br>Onset and Death          |
| 20   |                  | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | <b>S</b> c  | to (or as a conse   |                                  |  |                                    |   |                               |  |   |
| rtificate be ex  | he but           | dical          | IF FEMALE:   | d   |   |                                  |  |                                    |   |                               |  |   |
| The law requires that the death certificate be executed the has been signed by the attending physician and   | ched for use     | ysician/Me     | 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 1 🗆 Liv   | outcome pf preg<br>e birth 2 ☐ Fe<br>egnant at time of<br>known   | tal death 3                      | ⊒Ectopic pregnanc<br>⊒ Other <i>(specify)</i> _                          | 4                                  |   | 1                             | Date of delive                               | very<br>Day Year  |
| law requires that as been signed by  | uld be deta      | ed by Phy      | Part II. Other filmificant condi   | tions contributing to                             | death but not re  | esulting in the u                | inderlying cause giv   | en in Part I.                      | 23e. Did t                                |                               |  | the cause of death?   |
| Sicilar: The law re  | CI               | Completed      | Ify PE   | RLIPI   | Demir   | }                                |  |                                    | 24a. Was<br>auto<br>perfo<br>1 Yes        | an 24th                       | death?                                       | topsy findings available<br>ompletion of cause of<br>2 ☐ No |
| VICAL<br>/slcian: T  | lirector,        | Be             | 25. Was case referred to medic examiner?   | Hospital  | □Inpatient 2[   | ☐ ER/Outpatie                    | nt 3□ DOA Oth  | or:                                | Death (Check only o                       |                               | ther (Spec                                   | sifv)   |
| Attending Physician: r death. ector: After this certific   | e funeral o      | ation: To      | Z L ACCIDENT   | ing (M<br>tigation                                | te of Injury<br>lonth, Day Year)                                  | 28b. Time of Injury              | Wor  |                                    | 28d. Describe                             |                               |  |   |
| DIVIS<br>tal or Atte<br>'s after des<br>al Directo   | ed in by th      | Certification: | 3 ☐ Suicide 6 ☐ Could<br>4 ☐ Homicide deter  | minod   200, F16                                  | ace of injury - At<br>ilding, etc. <i>(Spec</i>                   | home, farm, st                   | reet, factory, office  |                                    | 28f. Location (<br>City or To             | Street and Nur<br>wn, State)  | nber or Ru                                   | ral Route Number,   |
| To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate ha   | pletely fill.    | Medical (      | (Check only 2   Medica<br>one)   | ing Physician: To<br>al Examiner: On the<br>and m | the best of my ki<br>e basis of exami<br>anner stated.            | nowledge, dea<br>nation and/or i | nvestigation, in my  | opinion, death o                   | ace, and due to the occurred at the time, | , date and plac               | e, and due                                   | to the cause(s)   |
| To t<br>with<br>To t   | COL              | Z              | 29b. Signature and title of certif   | MeyDS   |   |                                  |  | 7228                               |   | 29d. Date sign                | /2008  |   |
|  |                  |                | 30. Name and address of person Stephen P. Ca   | fferty, l   |   | 333 Gr                           |  | arkway,                            | Bldg. 5,                                  | Unit A                        |  | at Mills, M<br>20634  |
|  | Sta<br>gistr     | ar             | 31. Date filed (Month, Day, Yea  MAY 2 2 2008  | Man 32  | Hegistrar's Sig   | Seed .                           |  |                                    |   |                               |  |   |

|           |   |                     | State of State Amended#5perFH FCH  |   | artment of Health and Martificate of Death   |  | e.2008   | 17400  |
|-----------|---|---------------------|--|---|--|--|--|--|
|           |   |                     | Decedent's Name (First, Middle, Last)  |   |  | 2. Date of Death                                   |  | 3. Time of Death                                   |
| 100       | Physici<br>/Medic   |                     | RAYMOND  | BUTLER  |  | Month 6  | 2008   | 0335AM   |
|           | Examir  |                     | 4a. Facility Name (If not institution, give street and number HOLY CROSS HOS   |   | 4b. City, Town, or Location of Death SILVER SPRI   | NG ,   | 4c. County of Death MONTGO                     |  |
|           | Funeral<br>Director   |                     | 5. Social Security Number 6. Sex 1 M 2 F   | . Age (In yrs. last birthday)<br>G 9 Yrs.           | If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.   | 8. Date of Birth<br>(Month, Day, Yea<br>JUNC 14, 1 | 9. Birthpl<br>Count<br>1938 WASH               | ace (State or Foreign<br>ry)<br>IN 6 TON DC        |
|           | put w   |                     | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or Lo                               | cation   |  |  | d. Inside City Limits                              |
|           | Maryla<br>a-f shor<br>ified at  | ctor                | MD. MONTGOMERY   |   |  |  |  | 1 Yes 2 No   |
|           | with the  | al Direc            | 10e. Street and Number 5/43 EASTERN  | AVE   | 10f. Zip Code<br>20782   |  | Citizen of What Count                          | ry?  |
| 36        | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notifiled at | by Funeral Director |  | lent Ever in U.S. 13. Vises?                        | Mas Decedent of Hispanic Origin? (Sp<br>f Yes, specify Cuban, Mexican, Puerto<br>1 ☐ Yes 2 ☑ No Specify: | ecify Yes or No-<br>Rican, etc.)                   | 14. Race - America<br>Black, White, e          | etc.   |
| 15-0036   | in 72 hou<br>"natur?<br>Iedical E   | Completed           | 15. Decedent's Education<br>(Specify only highest grade completed)   | (Give   | dent's Usual Occupation<br>kind of work done during most of work<br>DO NOT use retired)                  | ring CC  | Kind of Business/Ind                           |  |
| 212       | d withi<br>giene.<br>er than<br>the M   | )om                 | Elementary/Secondary (0-12) College (1-4   | 5EL   | F EMPLOYED   | B  | CUSSINESS                                      | OWNER  |
| land      | ould be filed v<br>I Mental Hygie<br>narked other t<br>natic event, th  | To Be C             | 17. Father's Name ( <i>First, Middle, Last</i> )  LANCE BUTLER   |   |  | e (First, Middle, Maid<br>MAE ∆U                   | ,  |  |
| Maryl     | id 2 should<br>th and Mer<br>27 is marke<br>traumatic   | _                   | 19a. Informant's Name/Relationship (Type. Print)  JOAN A. BUTLER (   |   | ng Address (Street and Number or Run<br>3 EASTERN AVE  |  |  |  |
| a)        | Pages 1 and 2 lent of Health Int: If item 27 iny or other tra   |                     | 20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)                    | 20b. Place of Dispo                                 |  | Date 20c.  | Location - City or To                          | wn, State  |
| Baltimor  | permit. Pages<br>Department of<br>Important: If i<br>any injury or<br>once.   |                     | 21. Signature of Funeral Service Licensee  | 22  | 2. Name and Address of Facility A.A.D. WCST SOUTH ST   | ZY L. ROL  | LINS FON.                                      | Homt   |
|           |   |                     | 23a. Part1. Enter to disease, or complications that car shock, or and failure. List only one cause on ear                    | ch line.  |  | or respiratory arrest,                             |  | Approximate<br>Interval Between<br>Onset and Death |
| de.       | /Medical  |                     | disease or condition a.  | r as a consequence of):                             | ELPSIS.  |  |  |  |
| b         | Examiner  | er                  | Sequentially list conditions, if any, leading to immediate b. Due to (o  | r as a consequence of):                             | pneumone   |  |  |  |
|           | ecuted<br>and<br>-transit   | Examiner            | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | r as a consequence of):                             | urinany tract  | in fects   | in   |  |
| 8760,     | cate be executed oblysician and the burial-transit  | dical E             | d  |   |  |  |  |  |
| .O. Box 6 | eath certifie<br>attending p<br>for use as  | Physician/Me        | in the past 12 months?   | nt at time of death 5 ☐                             | ⊒Ectopic pregnancy<br>] Other (specify)  |  | 23d. Date of delive<br>Month                   | ry<br>Day Year                                     |
| <u>α</u>  | w requires that the de<br>been signed by the<br>should be detached  | by                  | Part II. Other significant conditions contributing to dea  | th but not resulting in the ur                      | nderlying cause given in Part I.   | 23e. Did tobaco                                    | co use contribute to th                        |  |
| Records,  | ne law requ<br>has been<br>ge 2 shoul   | Completed           |  |   |  | 24a. Was an autopsy performed                      | prior to cor<br>death?                         | osy findings available<br>npletion of cause of     |
| Vital     |   |                     | 25. Was case referred to medical   |   | 26 Place of Deal   | th (Check only one)                                | No 1 □ Yes                                     | 2 No   |
| r Vi      | Physicia<br>this cer<br>al direct   | To Be               | examiner?  | patient 2 ☐ ER/Outpatien                            | Othor:   | ome 5 Residence                                    | e 6 □Other (Specify                            | )  |
| on or     | iding Ph<br>th.<br>: After th<br>: funeral  |                     | 27. Manner of Death  1 Natural 5 Pending (Month) 2 Accident investigation  | f Injury<br>, Day Year) 28b. Time of<br>Injury      | f 28c. Injury at Work?  M 1 Yes 2 No   | 28d. Describe how in                               | njury occurred                                 |  |
| Division  | To the Hospital or Attending Physician: within 24 hours after cleath.  To the Funeral Director: After this certifical completely filled in by the funeral director,   | Certification:      | 3 Suicide 6 Could not be 28e. Place of   | of injury - At home, farm, str<br>g, etc. (Specify) | eet, factory, office   | 28f. Location (Street<br>City or Town, St          | and Number or Rura<br>tate)                    | l Route Number,                                    |
|           | e Hospita<br>24 hours<br>e Funera<br>etely fille  | Medical C           | 29a. Certifier (Check only one)  1 Certifying Physician: To the base and manner.   | sis of examination and/or in                        | h occurred at the time, date and place<br>vestigation, in my opinion, death occu                         | , and due to the cause<br>rred at the time, date   | e(s) and manner as st<br>and place, and due to | ated.<br>the cause(s)                              |
|           | To the To the To the Compl  | Me                  | 29b. Signature and title of certifier  |   | 29c. License number  | 29d.   | Date signed (Month,                            | Day, Year)   |
|           |   |                     | > Ksharua Ga   | Y   | 060826   |  | 5/6/08   |  |
|           | 5   |                     | 30. Name and address of person who completed cause   | of death (Item 23a) (Type,                          | Print)   | Can  | mo -   | 7 - 7 - 7 -  |
|           |   |                     |  | J CROSS HO.   | SPITAL SULVER  | SPRING   | 110.   | 000  |
|           | Sta<br>Regista  |                     | MAY 1 4 200  | Receive H.  | Small  | •  |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death  $5^{\frac{Month}{2}}1 - 2008$ 2:15 Pm Betty Mae Bonner 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Knoxville 1335 Brown Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-27-1922 Birthplace (State or Foreign Country)
 TTT 5. Social Security Number 7. Age (In vrs. last birthday) Months Days Min. Hours 1 □ M 2 🖺 F 85 217**-**18**-**4127 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21701 2500 Driftwood Court 1 **-** C 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ᡚNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) MD School for the Deaf Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Verna Victoria Buchanan Samuel F. Davis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $1403\ Brown\ Road\ Knoxville,\ MD\ 21758$ 19a. Informant's Name/Relationship (Type, Print) Donald Bonner Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hill Crest Mem Gn 5-24-2008 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. F.H. 106 East Church St. Frederick, MD 21701 21. Signature of Fungral Service Licensee M01176 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 1 HCPK erebrovascular Stroke Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 23e. Did tobacco use contribute to the cause of death? pertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

Be

MD

**Funeral** 

**Director** 

th and Mental Hygjene. 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, It a "ledical Examinar must by notified at

2 should be fill and Mental F is marked ott

1 and 2 s Health s item 27 i

permit. Pages 1 and 1 Department of Health Important; If item 27 any injury or other tr

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-trar Physician/Medical signed by the a <u>۾</u> Completed cate has page 2 s

requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Hospital or Attending Physician:

death.

certificate

this After thi funeral

within 24 hours after death

To the Funeral Director:
completely filled in by the

To the within 2.

Certification: To

Medical

IF FEMALE:

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an

autopsy performed 1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 No

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

Other: 4 \( \subseteq \text{ Nursing Home} \) 28c. Injury at Work?

5 Residence 6 □Other (Specify) 28d. Describe how injury occurred

5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifier

27. Manner of Death 1 Natural 2 Accident

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier 29c. License number D 51643 29d. Date signed (Month, Day, Year) 5-22-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hiren N. Shaw M.D. 65-C T.J. Drive Frederick, MD 21702

State Registrar

31. Date filed (Month, Day, Year) MAY 29



**ORIGINAL** 

|                     |   |                | For<br>State<br>Registrar   | State of Ma   | -                                   | •   | t of Health<br>of Deatl                                  |                 |  |            | 2008  | 17402  |
|---------------------|---|----------------|---|---|-------------------------------------|---|--|-----------------|--|------------|---|--|
|                     | Physici<br>/Medic   |                | 1. Decedent's Name (First, Middle,  | Florence  |                                     | Bake  |  |                 | 2. Date of Death<br>Month                    | Day 2 0    |   | 3. Time of Death   |
| -                   | Examin  |                | 4a. Facility Name (If not institution, s<br>The Johns Hopkins   | rive street and number)   |                                     |   | Town, or Location  more City                             |                 | ,  | 4c. Co     | ounty of Death  |  |
|                     | Funeral<br>Director   |                | 212-24-7223   | 4 D 14 a D =  | e (In yrs. last birthe<br>80 Yı     | Months  | 1 Year If Und<br>Days Hours                              | s Min.          | 8. Date of Birth<br>(Month, Day, )<br>August |            | Count   | ace (State or Foreign<br>ry)<br>rfield, PA                     |
|                     | f show  | or             | Usual Residence of Decedent  10a. State 10b. County  PA Frank   | lin   | 10c. City, Town                     |   |  |                 |  |            | 1   | 0d. Inside City Limits 1 ☐ Yes 2 ☑ No                          |
|                     | with the N<br>a or 28a-<br>be notifie   | Director       | 10e. Street and Number  11441 Airport R   |   | Waynesb                             | 10f. Zip  |  | _               | 10   | •          | n of What Coun  | ry?  |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funeral     | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  | 12. Was Decedent I  |                                     |   | 268<br>lent of Hispanic<br>ify Cuban, Mexic<br>X No Spec |                 | ify Yes or No-<br>ican, etc.)                | 14.        | USA<br>Race - America<br>Black, White, e<br>pecify: wh: | etc.   |
| Maryland 21215-0036 | within 72 hou<br>sne.<br>than "natural<br>e Medical Ex  | Completed      | 15. Decedent's<br>(Specify only highest<br>Elementary/Secondary (0-12)  | Education   | +)                                  | Decedent's Usua<br>Give kind of wo<br>life. DO NOT us<br>egiver | rk done during n   | nost of working | g  |            | of Business/Inc   |  |
| land 2              | uld be filed v<br>fental Hygie<br>rked other t<br>ic event, th  | 0              | 17. Father's Name (First, Middle, La<br>John Kepner   | st)   | Car                                 | egivei  |  |                 | (First, Middle, M                            | faiden Su  |   | ces  |
| Mary                | ind 2 shou<br>alth and N<br>27 Is mai<br>r traumat  |                | 19a. Informant's Name/Relationship<br>Earl H. Baker/spe   |   |                                     |   | Street and Number of Rd                                  |                 | Route Number,                                |            |   | Code)  |
| Baltimore,          | Pages 1 and the sent of He sent of He sent of He sent of the sent |                | 20a. Method of Disposition 1√ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe  |   |                                     | Disposition (Nar<br>crematory or o                              |  | May 23          | ate 2<br>3, 2008                             |            | tion - City or To                                       |  |
| Balti               | permit. Departm Importa any Inju  |                | 21. Signature of Funeral Service Lic  | ensee<br>Sullos Mú  |                                     | 22. Name ar   | d Address of Fa<br>Broad St                              | Grov            |  | sox        | Funeral   | Home, Inc.   |
|                     | Physician<br>/Medical   |                | 23a. Part V Enter the disease, or or<br>shock, or heart failure. List on<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)         | ly ône cause on each lin<br>aa.                                 | e.  SIS a consequence of            | ):  |  |                 |  | est,       |   | Approximate<br>Interval Between<br>Onset and Death<br>12 hours |
| 1760,               | ate be executed nysician and the burial-transit   | dical Examiner | Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b   | ute<br>a consequence of             | ).  | th F   | AILU            | IRE  |            |   | 18 hours   |
| Box 68              | The law requires that the death certifica<br>tte has been signed by the attending ph<br>page 2 should be detached for use as the  | Physician/Me   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  | 23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown | 2 - Fetal death                     | 3 ☐ Ectopic p 5 ☐ Other (sp                                     |  |                 |  | 236        | d. Date of delive                                       | ery<br>Day Year  |
| ds, P.O.            | uires that t<br>signed by<br>ild be deta  | by             | Part II. Other significant condition  | s contributing to death b                                       | ut not resulting in                 | the underlying  | cause given in F   | Part I.         | 23e. Did tob                                 |            |   | he cause of death?<br>ably 4 🔼 Unknown                         |
| Records,            | The faw require<br>te has been sig<br>page 2 should   | Completed      | <u></u>   |   |                                     |   |  |                 | 24a. Was an autopsy perform                  | v          | prior to co<br>death?                                   | psy findings available impletion of cause of 2                 |
| /ital               | sician: The certificate irector, pa   | Be C           | 25. Was case referred to medical examiner?  | Hamital   |                                     |   |  | lace of Death   | (Check only one                              | )          |   |  |
| <del>_</del>        | Physic<br>this ce<br>ral dire   | ပု             | 1 ☐ Yes 2 No 27. Manner of Death  | Hospital: 1 XInpatie  |                                     | patient 3 Do  | OA Other: 4 =  |                 | e 5 Reside<br>8d. Describe ho                |            |   | /)   |
| LO                  | ding F<br>h.<br>After t<br>funer  | tion:          | 1 Natural 5 ☐ Pending   | (Month, Day   |                                     | jury  | Work?<br>1 ☐ Yes 2                                       |                 | od. Describe no                              | W Injury C | occurred  |  |
| Division of Vital   | or Atten<br>fter deat<br>irector:<br>in by the  | Certification: | 2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin   | t be 28e Place of init  | ury - At home, farr<br>c. (Specify) | n, street, factory  |  |                 | 8f. Location (St.<br>City or Town,           |            | Number or Run   | al Route Number,   |
|                     | the Hospital of thin 24 hours a the Funeral Dimbletely filled in  | Medical C      | (check only 2 Medical E   | Physician: To the best oxaminer: On the basis o and manner st   | examination and                     |   |  |                 |  |            |   |  |
|                     | To the within 2 To the comple   | M              | 29b. Signature and title of certifier   | MD  |                                     |   | E. License numb  |                 |  | 9d. Date   | signed (Month,  | 2008   |
|                     |   |                | 30. Name and address of person w  | ho completed cause of o   |                                     | Type, Print)  |  | EUU M           | lorth Wel                                    | fa St      | Raltimo   | e, MD, 21287   |
|                     | Sta   | ite            | 31. Date filed (Month, Day, Year)   | 22. Registra  | ar's Signature                      | 1 45  |  | 000 1           | 101111 1101                                  | .e ot,     | Daranio   | C, 111D, 21201   |

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 7: 10P.<sup>M</sup> May 2008 Evangeline K. Commeree /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Mitchellville Prince George's Villa Rosa Nursing Home If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Jul 6, 1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 185-18-9533 Director 86 Pennsylvania Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County rthan "natural", or items 23a or 28a-f show the Mudical Examinar mast be multified at VA Fairfax Alexandria 1 ☐ Yes 2X No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 22309 5312 Remington Drive USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status hours after 1 ☐ Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: Completed by 3 ₩ Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Pages 1 and 2 should be filed vitnent of Health and Mental Hygie tant: If item 27 is marked other tigury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kunagunda Wisniecki Julius Kellner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5312 Remington Dr, Alexandria, VA 22314 James S. Commeree (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🙀 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or 06/10/2008 `4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat. Cem. Arlington, VA 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Demaine Funeral Home 9 520 S. Washington St, Alexandria, VA 22314 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one chuse on each line. Immediate Cause (Final 1-enotic Physician Athnosc steart disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury death certificate be executed burial-transit Emention that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. nding physicien Physician/Medical the as IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter 3 Ectopic pregnancy ō in the past 12 months? Month Year Day 5 Other (specify) 1 Yes 2 No detached the 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 X No 1 T Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 2 No 1 ☐ Yes 2 1 No 1 🗆 Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient ö 2 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Medical Certification; After Attending 1 Natural 2 Accident 5 Pending 1 Tes 2 No death. f Director: A 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide hours after 0 within 24 hours a To the Funeral [ To the Hospital 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane, Bowie, Rakesh Aurora MD MD 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signa State Registrar 2008

To the Ho within 24 I

State Registrar

101 31. Date filed (Month, Day, Year) MAY 1 5 2008

29b. Signature and title of certifier

32. Registrar's Signat

ess of person who completed cause of death (Item 23a) (Type, Print)

WESTON

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 9 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Elizabeth Carter 14:52 P 2008 May 12, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Fort Washington Prince George's Fort Washington Hospital Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Unde Hours 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 □ M 2 12 F Director 578-36-9835 83 April 15, 1925 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 Yes 2 No Maryland Prince George's Fort Washington Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 United States 8515 Colonel Seward Drive filed within 72 hours after death v Hygiene. ther than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: African 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ 3√ Widowed 4 Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mail Handler Government permit. Pages 1 and 2 should be filed Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event. th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert E. Hart Marie Lewis ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rose Carter-Melson / Daughter 8515 Colonel Seward Dr. Ft. Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gilliam Bapt Ch Cemt May 17, 2008 Louisa, VA 22. Name and Address of Facility Stewart Funeral Home Inc. ature of Fun vol Serv 4001 Benning Road, NE Washington, DC 20019 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END Physician Stage resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consequence of Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Diabere burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the as attending properties of the second IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 menths? 1 ☐ Yes No 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 4 Unknown 1 ☐ Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has t page 2 s autops certificate 1□ Yes Hospital or Attending Physician: director, 25. Was case referred to medical examiner? To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 | Inpatient 2 R/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20

State Registrar

31. Date filed (Month, Day, Year)

MAY 1 5 2008



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #8 Per FH g889 6/10/08 JH Certificate of Death Reg. No. 1 - For State Registrar Reg. No. 2 6 8 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 15:39 PM lliam 200 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fagility Name (If not institution, give street and number, Examiner Acomico If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth
(Month Day Year)
Feb 17,1938 9. Birthplace (State or Fgreign 5. Social Security Number A. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months 218-34-8173 Yrs Director Mary lance Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the "redical Exactive" rust be notified at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 21804 Funeral enue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No If Yes, Give Year or Dates; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic events. Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: Completed by Black 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ILL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21826 Brother truitland W. 20a. Method of Disposition

1 → Burial 2 □ Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State -10-08 4cres Mem Park 4 Donation 5 Dother (Specify) 5 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Heme Mussell Maryland cotto Approximate Interval Between Onset and Death 23a, Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Anoxic encephalopal **Physician** /Medical Due to (or as a consequence of): Examiner postycemia Sequentially list conditions, if any, leading to himselfact cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of) burial-transi and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the as IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. the detached 9 Unknown 9 Unknown s been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1/211, Ws Diabetes 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed 2 🗆 No Division of Vital 1 ☐ Yes 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 14100 1 🔲 Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H006453 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Felder 100 Carroll St. , md, 21801 egistrar's Signature 31. Date filed (MM/ANey, Yea 2 2008 State Registrar

|                              |  |                  | 1 - For<br>State<br>Registrar Amend Item 11                                  | State of Mar<br>Ler wife, 38                    | yland / E<br>31 7/25/0     | epartme<br><b>Celtific</b> a      | nt of H<br>te of L        | ealth and N<br>Death                     |                                   | iene                      | 866                                    | 17407  |
|------------------------------|--|------------------|--|---|----------------------------|-----------------------------------|---------------------------|--|-----------------------------------|---------------------------|--|--|
|                              | E.   |                  | 1. Decedent's Name (First, Middle, Las                                       | ***   |                            |                                   |                           |  | 2. Date of Deat                   | th                        | V                                      | 3. Time of Death                               |
|                              | Physici<br>/Medio  |                  | ROY SHELTO   | N (   | CANTER                     | 2                                 |                           |  | Month<br>MAY                      | 21                        | 2008                                   | 9:55 P   |
|                              | Examir   |                  | 4a. Facility Name (If not institution, give                                  | street and number)                              |                            | 4b. Cit                           | y, Town, or               | Location of Death                        |                                   | 4c. Cou                   | inty of Death                          |  |
|                              |  |                  | GENESIS LA PLAT  |   |                            |                                   | A PL                      |  |                                   | C                         | HARLE                                  |  |
|                              | Funeral  |                  | 5. Social Security Number 6. Se  | ax 7.Age(<br>Day 2□F                            | In yrs. last birt          | hday) If Und<br>Month             | ler 1 Year<br>s Days      | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birth<br>(Month, Day,  | , Year)                   | 9. Birthp<br>Cour                      | lace (State or Foreign<br>htry)                |
|                              | Director   |                  | 215-36-4922 Usual Residence of Decedent                                      |   | 90                         | 113.                              |                           |  | Mar.6,                            | 1918                      | MAR                                    | 'LAND  |
|                              | land<br>ow   |                  | 10a. State 10b. County   | 1   | Oc. City, Town             | or Location                       |                           |  |                                   |                           | 1                                      | 0d. Inside City Limits                         |
|                              | Man<br>a-f et  | tor              | MD CHARLE  | s   | WALD                       | ORF                               |                           |  |                                   |                           |  | 1 ☐ Yes 2√CXNo                                 |
|                              | or 28  | lrec             | 10e. Street and Number   |   |                            | 10f. 2                            | Zip Code                  |  | 1                                 | 0g. Citizen               | of What Cour                           | ntry?  |
|                              | 23a  | Funeral Director | 12133 LA PLATA   | ROAD  |                            |                                   | 2060                      | 2  |                                   | U.                        | S. A.                                  |  |
|                              | teme<br>frame  | nue              | 11. Marital Status   | 12. Was Decedent Every Armed Forces?            | er in U.S.                 | 13. Was Dec                       | edent of Hi<br>ecify Cuba | spanic Origin? (Sp<br>n, Mexican, Puerto | pecify Yes or No-<br>Rican, etc.) |                           | Race - Americ<br>Black, White,         |  |
| 36                           | s afte   | by Fu            | 1 ☐ Never Married 2 ☐ Married<br>3 ☐ Widowed 4 ☐ Pivorced                    | 1 ☐ Yes 2 ☐ No<br>If Yes, Give                  |                            | 1 ☐ Yes                           | 2 No                      | Specify:                                 |                                   | Spe                       | ec <i>ify:</i> Wil                     | HITE   |
| 8                            | within 72 hours after death with the Maryland<br>ene.<br>than "naturel", or Iteme 23a or 28a-f ehow<br>fra Madical Examiner must be notified at  | ed b             | 15. Decedent's Ed  | Year or Dates:                                  | 162                        | Decedent's Us                     | ual Occupa                | ation                                    |                                   | 16h Kind c                | of Business/In                         |  |
| 21215-0036                   | in 72<br>n "na<br>Nedic  | Completed        | (Specify only highest grad   | de completed)                                   |                            | (Give kind of v                   | vork done d               | during most of work                      | king                              | TOD. TURIS                | 7 0001110333111                        | dustry   |
| 212                          | d with   | mo               | Elementary/Secondary (0-12)  | Coltege (1-4or 5+)                              | F                          | ARMER                             |                           |  |                                   | $\mathbf{F}^{p}$          | ARMINO                                 | 3  |
| g                            | e filed<br>al Hygid<br>I other<br>vent, II   | Be C             | 17. Father's Name (First, Middle, Last)                                      |   |                            |                                   |                           | 18. Mother's Nam                         | e (First, Middle, I               | Maiden Sur                | name)                                  |  |
| <u>a</u>                     | Ments<br>Ments<br>arked  | ToE              | SAMUEL LEVI C  | ANTER   |                            |                                   |                           | NINA                                     | MARIE                             | CANTI                     | ER                                     |  |
| Maryland                     | and and in me  | 0 6              | 19a. Informant's Name/Relationship (7  | ype, Print)                                     | 19b.                       | Mailing Addre                     | ss (Street a              | and Number or Ru                         | rai Route Number                  | r, City or To             | wn, State, Zip                         | Code)  |
|                              | and<br>lealth<br>m 27<br>her tr  |                  | JOHN S. CANTER   | /SON  |                            |                                   |                           | THORPE                                   |                                   |                           |  | VA22315  |
| Baltimore,                   | Peges 1<br>nent of H<br>int: If Ite<br>iry or ot   |                  | 20a. Method of Disposition 1 ☐ Burial 2√C remation 3 ☐                       | Removal from State                              | cemeter                    | Disposition (A<br>y, crematory of | r other plac              |  | Date                              |                           | on - City or To                        |  |
| Ħ                            | t. Pe<br>rtmen<br>rtant:<br>njury  |                  | 4 □Donation 5 □Other (Specify  |   | METRO                      | POLITA                            |                           |  |                                   |                           | ANDRIA                                 | •  |
| Bal                          | permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show emportant: or other traumatte event, I'm Medical Endriner must be notified at Once. |                  | 21. Signature of Funeral Service Licens                                      | 7 (60.  | 00641                      | 5635                              | wash:                     | is of Facility Rai                       | ymond F<br>Ave.,La                | unl.<br>Pla               | Servi<br>ta,MD                         | ce,P.A.<br>20646                               |
|                              |  |                  | 23a. Part1. Enter the disease, or composhock, or heart failure. List only of | lications that caused thone cause on each line. | e death. Do n              | ot enter the m                    |                           |  |                                   |                           |  | Approximate<br>Interval Between                |
| ķ.                           | Physician  |                  | Immediate Cause (Final disease or condition                                  | Soin.   | MOON                       | S, CEN                            | رم ا                      | AREN                                     | AMEV                              | U1 %                      | tex.                                   | Onset and Death                                |
|                              | /Medical<br>Examiner   |                  | resulting in death)  | Due to (or as a c                               | consequence                | of):                              |                           | "ARED"                                   |                                   |                           |  |  |
|                              |  | _                | Sequentially list conditions, if any, leading to immediate                   | b. HOVE   | WCVEJ                      | 2. 173                            | しから                       | risco                                    | RAGOSI                            | >,                        | n n n                                  | vicere.  |
|                              | ted<br>nsit  | Examiner         | Cause. Enter Underlying<br>Cause (Disease or injury                          | 500 10 (0, 00 0                                 | onouquonoo                 | ,,,                               |                           |  |                                   |                           |  | )  |
| ,                            | execu<br>n and<br>ial-tra  | Exa              | that initiated events<br>resulting in death) Last                            | Due to (or as a c                               | consequence                | of):                              |                           |  |                                   |                           |  |  |
| 8760                         | ficate be executed<br>physicien and<br>s the burial-transit  | dical            |  | d   |                            |                                   |                           |  |                                   |                           |  |  |
|                              | tifical<br>og phy<br>as th   | ledi             |  |   |                            |                                   |                           |  |                                   |                           |  |  |
| .O. Box                      | that the death certifi<br>ed by the attending<br>detached for use as   | Physician/Me     | 230. Was decedent pregnant   | 23c. If yes, outcome of<br>1 ☐ Live birth 2     | pregnancy<br>□ Fetal death | 3 □Ectopic                        | pregnancy                 |  |                                   | 23d.                      | Date of delive                         | •  |
|                              | e dea<br>the at<br>ned fo  | SIC              | in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown                            | 4☐ Pregnant at tin                              |                            | 5 Other (                         |                           |  |                                   |                           | Month                                  | Day Year                                       |
| 0                            | d by<br>fetach   | Phy              | Part II. Other significant conditions co                                     | antichuting to dooth but                        | nat raquitina in           | the medechine                     |                           | - in Doct I                              | 220 Did to                        | haasa uga d               | antsibuto to t                         | ne cause of death?                             |
| Š,                           | 8 60   | by               | Fait II. Other significant conditions of                                     | ontributing to death but i                      | not resulting in           | the underlying                    | cause give                | en in Part I.                            |                                   | es 2□N                    |  |  |
| Ö                            | w require<br>been si<br>should t   | Completed        |  |   |                            |                                   |                           |  | 1                                 |                           |  |  |
| 3ec                          | hasl<br>pe 2 s   | mp               |  |   |                            |                                   |                           |  | 24a. Was a autops perform         | y                         | 4b. Were auto<br>prior to co<br>death? | psy findings available<br>mpletion of cause ol |
| a                            | n: Th<br>licate<br>r, pag  |                  |  |   |                            |                                   |                           |  | 1 ☐ Yes                           | 2 No                      | 1 🗆 Yes                                | 2 No   |
| <u>=</u>                     | ding Physician: The In. After this certificate hat funeral director, page  | o Be             | 25. Was case referred to medical examiner?  1 Tyes 2 No                      | Hospital:<br>1 ☐ Inpatient                      | 2 ER/Out                   |                                   | Othe                      |  | th (Check only on                 |                           | 011 (0)                                |  |
| ō                            | Phy<br>or this<br>oral d   | $\vdash$         | 27. Manner of Death  | 28a. Date of Injury                             | 28b. T                     | ime ol                            | 28c. Injury<br>Work       |  | ome 5 Reside                      |                           |  | y)   |
| 0                            | nding<br>tth.<br>:: Afte   | atio             | 1 Naturat 5 ☐ Pending<br>2 ☐ Accident investigation                          | (Month, Day Y                                   | ′ea <i>r)</i> Ir           | njury<br>M                        |                           | t?<br>Yes 2 □ No                         |                                   |                           |  |  |
| Division of Vital Records, I | or Attendition death   | Certification:   | 3 Suicide 6 Could not be<br>4 Homicide determined                            | 28e. Ptace of Injury<br>building, etc. (        |                            | m, street, lacto                  | ory, office               |  | 28f. Location (Si<br>City or Town | treet and Ni<br>n, State) | umber or Rura                          | N Route Number.                                |
| _                            | To the Hospital or Attending Physician: within 42 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it  |                  | 29a. Certifier 1 Certifying Phy  | /sician: To the best of r                       | my knowledge               | , death occurre                   | d at the tim              | e, date and place                        | and due to the c                  | ause(s) and               | 1 manner as s                          | tated.   |
|                              | the H<br>in 24<br>the F<br>iplete  | Medical          | one)   | and manner state                                | d.                         |                                   |                           |  |                                   |                           |  | 11   |
|                              | with<br>Con  | 4                | 29b. Signature and title of certifier  | A IST   | V.                         |                                   | 9c. License               | number                                   | C <sub>i</sub>                    | yd. Date si               | gned (Month,                           | uay, Year)                                     |
| ,                            |  |                  | I Mile   | JUNO.   | -                          |                                   | シ                         |  | (                                 | 2                         | 1501                                   |  |
|                              |  |                  | Name d address of rs in who o  | completed cause of deal                         |                            | 12.1                              | JAIA                      | DORF.V                                   | w La                              | 0607                      |  |  |
|                              | Sta  | te               | 31. Date filed (Month, Day, Year)  | 32. Registrar's                                 |                            | V                                 | VIL                       | , V                                      |                                   |                           |  |  |
|                              | Registr  |                  | MAY 2. 9 2008  | Ag  | M de                       | MARK D                            |                           |  |                                   |                           |  |  |

DHMH 17 Rev 1/2001

ORIGINAL

17408

|             |   |                | 1 - For<br>State<br>Registrar  | State of Ma                                     |                      | Certificate of  |  |                                  | eg. No.                   | 0 1/400  |
|-------------|---|----------------|--|---|----------------------|---|--|----------------------------------|---------------------------|--|
| В           | Physici   | an             | 1. Decedent's Name (First, Middle, Las   |   |                      | 0 1   |  | 2. Date of Deat<br>Month         | th<br>Day Yea             | 3. Time of Death                                       |
| gradust.    | /Medic  |                | Elizabeth  | \   |                      | 1201  | ad   | may                              | 13300                     | \$ 5:30 A M  |
|             | Examir  | er             | 4a. Facility Name (If not institution, give  |   | sep conte            |   | or Location of Death                         | G                                | 4c. County of De          | /-· (  |
|             |   | *              | 5. Social Security Number 6. Se  |   |                      |   | If Under 24 Hrs.                             | 0 Date of Birth                  | Balti                     |  |
|             | Funeral<br>Director   |                | 1[   |   | (In yrs. last birth  | Months Dave   | Hours Min.                                   | 8. Date of Birth<br>(Month, Day, | , Year)                   | irthplace (State or Foreign)<br>Country)               |
|             | 4   |                | 200-24-9279 Usual Residence of Decedent  |   | 76                   |   |  | July 8,                          | 1931   Pei                | nnsylvania   |
|             | yland<br>at   |                | 10a. State 10b. County   |   | 10c. City, Town      | r Location  |  |                                  |                           | 10d. Inside City Limits                                |
|             | a-f sl  | ctor           | Virginia Fai   | rfax  | Sprin                | gfield  |  |                                  |                           | 1 □Yes 2 No  |
|             | or 28   | Director       | 10e. Street and Number   |   |                      | 10f. Zip Code   |  | 1                                | 0g. Citizen of What       | Country?   |
|             | 23a<br>ust b  |                | 6608 Huntsman Blvd   | •   |                      |   | 22152  |                                  | United S                  | tates  |
|             | tems<br>ler m   | Funeral        | 11. Marital Status   | 12. Was Decedent E<br>Armed Forces?             | ver in U.S.          | <ol> <li>Was Decedent of I<br/>If Yes, specify Cub</li> </ol> | Hispanic Origin? (Spe<br>an, Mexican, Puerto | ecify Yes or No-<br>Rican, etc.) | 14. Race - Ar<br>Black, W | nerican Indian,<br>hite, etc.                          |
| 36          | be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at | by F           | 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☑ N<br>If Yes, Give<br>Year or Dates: | 0                    | 1 ☐ Yes 2 🙀 No  | Specify:                                     |                                  | Specify:                  | unnaf on   |
| 21215-0036  | 2 hou<br>atura<br>cai E   | ted            | 15. Decedent's Edu   |   | 16a. D               | ecedent's Usual Occup   | pation                                       |                                  | 16b. Kind of Busines      | Aucasian<br>ss/Industry                                |
| 215         | e.<br>an "n<br>Medi   | Be Completed   | (Specify only highest grad   | College (1-4or 5-                               | -) (7                | Give kind of work done<br>fe. DO NOT use retire               | during most of working)                      | ing                              |                           |  |
|             | d wit   | P P            |  | 4   |                      | Teach   | ner  |                                  | Educ                      | ation  |
| nd          | be filed<br>Ital Hygl<br>Id other<br>event, t   | Be (           | 17. Father's Name (First, Middle, Last)  |   |                      |   | 18. Mother's Name                            | e (First, Middle, I              | Maiden Surname)           |  |
| Na          | should be filed<br>ind Mental Hygl<br>s marked other<br>umatic event, t   | 은              | Unknown  |   |                      |   | Pearl  | Welsh                            | ı                         |  |
| Maryland    | S ar  |                | 19a. Informant's Name/Relationship (T)   | ирө. Print)                                     | 19b. N               | lailing Address (Street                                       | and Number or Rura                           | al Route Number                  | r, City or Town, State    | , Zip Code)  |
|             | 1 and 2<br>Health<br>em 27  |                | Steven DeLong/Son  |   |                      | 51 Watersh  |  |                                  |                           |  |
| 0           | W C   |                | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ I  | Removal from State                              | cemetery,            | isposition (Name of<br>crematory or other pla                 | ice)   | Date                             | 20c. Location - City      | or Town, State   |
| altimore,   | nit. Pag<br>artmen<br>ortant:<br>injury<br>e.   |                | 4 ☐ Donation 5 ☐ Other (Specify,   |   | Arlingt              | on Nationa  |  | 8,2008                           | Arlington                 | ı, Virginia  |
| Ba          | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.  |                | 21. Signature of Funeral Service Licens  | ee .  |                      | 22. Name and Addre  | •  |                                  |                           |  |
|             | 402 40  |                | Ole Part Spice the linear execute  | lications that assumed                          |                      |   |  |                                  |                           | Rd.,Spr.,VA  |
| 6           |   |                | 23a. Part1. Enter the list ase, or comp shock, or heart fail is. List only of Immediate Cause (Final | ne cause on each lin                            | e.                   | enter the mode of dyl   | rig, such as cardiac (                       | or respiratory arre              | est,                      | Approximate<br>Interval Between<br>Onset and Death     |
|             | Physician<br>/Medical   |                | disease or condition resulting in death)   | a. Heck   | uthr                 | 10  |  |                                  |                           | ninutes  |
|             | Examiner  |                |  | Due to (or as a                                 | c quence of)         |   | ~  | -1 - 1-                          | - (                       | 10022  |
|             | ***   | e              | If any learning to inquestiate   | b. Due to (or )s a                              | consequence of       | 71021100  | ras Le                                       | CHANG                            | 01                        | 200,2  |
|             | uted<br>d<br>ansit  | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events                               | cent  | lahar                |   |  |                                  |                           |  |
| ,           | exec<br>n and<br>ial-tra  | Exa            | resulting in death) Last   |   | consequence of)      |   |  |                                  |                           |  |
| 68760,      | icate be executed<br>physician and<br>s the burial-transit  | cal            |  | a Chros   | iic Ok               | sitzenta  | 2 Pulas                                      | Luce                             | Discord                   | 12055  |
| 9           | rtifica<br>ng ph<br>as th   | <b>Jedical</b> |  |   |                      |   |  |                                  |                           |  |
| ž<br>R<br>R | that the death certificate be executed<br>ed by the attending physician and<br>detached for use as the burial-transif   | an/N           | 23b. was decedent pregnant   | 23c. If yes, outcome p<br>1□Live birth          |                      | 3 ☐ Ectopic pregnanc  | ev.  |                                  | 23d. Date of d            |  |
|             | ed fo   | Physician//    | in the past 12 months?<br>1 ☐ Yes 2 🗷 No   | 4□Pregnant at                                   |                      | 5 Other (specify)   | · · · · · · · · · · · · · · · · · · ·        |                                  | Month                     | Day Year   |
| J<br>O      | law requires that the<br>as been signed by th<br>2 should be detache  | Phy            | 9 ☐ Unknown  |   |                      |   |  | T                                |                           |  |
| Ś           | igned<br>be de  | 5              | Part II. Other significant conditions co   | ntributing to death bu                          | t not resulting in t | ne underlying cause giv                                       | ven in Part I.                               |                                  |                           | to the cause of death?                                 |
| ecords,     | w requires to be should be  | ted            | rachagic di  | 10 TOF  | aprice.              | 50,000  | 527.110C                                     | 1 <b>X</b> Ye                    | es 2 No 3                 | Probably 4 Unknown                                     |
| ည           | e 2 sh  | Completed      | Thoracic Ac  | tic Ac  | auril.               |   |  | 24a. Was a<br>autops             | sy prior t                | autopsy findings available<br>o completion of cause of |
|             | : The cate ha   | Sol            | Rocurect Pro   | moon 1  | $\sim$               |   | -  | perforr<br>1□ Yes                | med? death<br>2⊠No 1⊡Y    | ?<br>es 2□No   |
| Vitai       | Physician: The law<br>this certificate has tral<br>director, page 2 s   | Be             | 25. Was case referred to medical examiner?   | Hospital:                                       | ,                    | - Cul   | 26. Place of Death                           | n (Check only on                 | e)                        |  |
| Ö           | this<br>al di   | 2              | 1 Yes 2 No 27. Manner of Death   | 28a. Date of Injur                              | t 2 ER/Outp          | Ment 3 DOA  |  |                                  | ence 6 Other (S           | pecify)  |
|             | Jing<br>After<br>fune   | ion            | Natural 5 ☐ Pending  | (Month, Day                                     |                      | ry Wo   | rk?<br>]Yes 2□No                             | 28d. Describe no                 | ow injury occurred        |  |
| UNISION     | or Attending<br>after death.<br>Director: After<br>in by the funer  | icat           | 2 Accident investigation 3 Suicide 6 Could not be  | 28e. Place of injur                             | v - At home, farm    | , street, factory, office                                     |  | 28f Location (St                 | treet and Number or       | Rural Route Number,                                    |
| 2           | i di fit di   | Certification: | 4 ☐ Homicide determined  | building, etc.                                  | (Specify)            | ,,,,  |  | City or Town                     | n, State)                 | ridia riddo ridinoci,                                  |
|             | e Hospital or<br>24 hours afte<br>e Funeral Dir<br>letely filled in I   |                | 29a. Certifier Certifying Phy  | i<br>sician: To the best o                      | f my knowledge, o    | leath occurred at the ti                                      | ime, date and place,                         | and due to the c                 | ause(s) and manner        | as stated.   |
|             | To the Hos<br>within 24 ho<br>To the Fun<br>completely  | Medical        | (Check only 2 Medical Exam one)  | iner: On the basis of<br>and manner stat        | examination and/     | or investigation, in my                                       | opinion, death occur                         | red at the time, d               | late and place, and c     | ue to the cause(s)                                     |
|             | To the within 2 To the Complet  | M              | 29b. Signature and title of certifier  |   |                      | 29c. Licens   | se number                                    | 2                                | 9d. Date signed (Mo       | nth, Day, Year)  |
|             |   |                | MIS S  | N   | ~~                   | Do  | 04383  | ,                                | nay 1                     | 3 2008   |
| 2(          | 15)   |                | 30. Name and address of person who co  |   | ath (Item 23a) (Ty   | pe, Print)<br>5 Hapkins                                       | sicrice ?                                    | یدی وز                           | rele isc                  | 174-06 31974   |
|             | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year) MAY 1 5 2008   | 32. Registra                                    | 's Signature         |   |  |                                  |                           |  |
|             |   |                |  |   | 1                    |   |  |                                  |                           |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1240 AM 500 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 260 (a) amballs Anne Annal trapel ( If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 4/26/1938 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1□M 21 F 578-48-6747 70 Director Washington, D.C Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2607 Chapel Lake Dr., Apt.#203 21054 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates; Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status Black. White, etc. 1- Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖺 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Insurance Agent Insurance 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Hardesty ဥ Mary Holiday 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Donaldson / Son 12601 Clark Meadows Ct. Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Resurrection Cemetery 5/16/2008 | Clinton, MD 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service License 6512 NW Crain Hwy. Bowie, MD 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician MON /Medical Due to (or as a conseque of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause fusease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 9 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No. 24a. Was an autopsy performed?

Yes 2 No 1∐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 1 Yes 2 No Other: 4 Nursing Home 2 ER/Outpatient 3 DOA 5-Expesidence 6 □Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; / 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

of (20)

State Registrar 31. Date filed (Month, Day, Year)

MAY 1 5 2008

Tay Rhee 9W Bestgate Rd Sate 300 Ampolio 32. Registrar's Signature

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Frederick Darling 12:34 AM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death 4c. County of Death Examiner HOSPITC aure Prince Regional Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/8/1948 6. Sex 1 1 1 1 2 □ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In rs. last birthday) **Funeral** Days Months Hours Yrs, 216-60-2754 59 Connecticut Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show r 28a-f show notified at 1 ☐ Yes 2 XNo MD Prince George's Laurel Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? "natural", or items 23a or 8803 Royal Ridge Lane 20708 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 → Married 1 ☐ Yes 2 No ģ Specify: 3 Widowed 4 Divorced White Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
Prince George's County 15. Decedent's Education (Specify only highest grade completed) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Public School System Teacher and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Snow Fongeallaz 17. Father's Name (First, Middle, Last) Edwin F. Darling, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Laurel, MD 20708 Cynthia R. Darling / Wife 8803 Royal Ridge Lane 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Metropolitan 20c. Location - City or Town, State May 18, Pages ' 2008 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Crematory Beall Funeral Home 21. Signature of Funer Sep 22. Name and Address of Facility Bowie, MD 6512 NW Crain Hwy. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or con shock, or heart failure. List only ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line, Immediate Cause (Final Physician Atherosclevo eav s disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Diabetes if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed and burial-trar Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 9☐Unknown 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 1□ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 this 27. Manner of Death 28a. Date of Injury (Month, Day 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Box 68760, P.0. or Vital Records, Division

Baltimore, Maryland 21215-0036

Medical State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10180000 31. Date filed (Month, Day, Year) 2008

29a, Certifier

(Check only one)

29b. Signature and title of certifier

van 7400 32. Registrar

and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

TODK

| Physiciar<br>/Medica<br>Examine |  |
|---------------------------------|--|
| Funeral                         |  |
| Director                        |  |

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

| 1 - State<br>Registrar  |   | C                                    | Certificate of   | Death                                  | Re                                     | g. No.2008                         | 1741  |  |  |  |  |  |
|---|---|--------------------------------------|--|--|--|------------------------------------|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle   | . Last)                                 |                                      |  |  | 2. Date of Death<br>Month              | _                                  | 3. Time of Death                                    |  |  |  |  |  |
| Anita Mar   | gareta Da                               | h1man                                |  |  |  | Day Year 2008                      | 9:00 am   |  |  |  |  |  |
| 4a. Facility Name (If not institution   | give street and number)                 |                                      | 4b. City, Town, o  | r Location of Deat                     | h                                      | 4c. County of Deat                 | n   |  |  |  |  |  |
| Casey House   |   |                                      | Rockv  | ille                                   |  | Montgom                            | ery   |  |  |  |  |  |
| 5. Social Security Number   | 6. Sex 7. Ag<br>1 ☐ M 2 🖾 F             | e (In yrs. last birtho               | Monthe Dave  | If Under 24 Hrs<br>Hours Min           | (Month, Day,                           | Year) Co.                          | nplace (State or Foreig<br>untry)                   |  |  |  |  |  |
| 087-50-3922   | 1   W 2   2                             | 53 <sup>Yrs</sup>                    | s.   |  | April 27                               | , 1955 C                           | )hio  |  |  |  |  |  |
| sual Residence of Decedent  a. State 10b. County 10c. City, Town or Location  |   |                                      |  |  |  |                                    |   |  |  |  |  |  |
|   |   | Toc. Oily, Towito                    | Location   |  |  |                                    | 10d. Inside City Limits 1 □ Yes 2 ☒ No              |  |  |  |  |  |
| Maryland Washi  | ngton                                   | Hager                                |  |  |  |                                    |   |  |  |  |  |  |
| 10e. Street and Number  |   |                                      | 10f. Zip Code  |  | 10                                     | g. Citizen of What Co              | untry?  |  |  |  |  |  |
| 241 East Irvi   |   |                                      | 21742  |  |  | United St                          |   |  |  |  |  |  |
| 11. Marital Status  | 12. Was Decedent<br>Armed Forces?       | Ever in U.S.                         | <ol> <li>Was Decedent of H<br/>If Yes, specify Cub:</li> </ol> | lispanic Origin? (<br>an, Mexican, Pue | Specify Yes or No-<br>rto Rican, etc.) | 14. Race - Ame<br>Black, White     |   |  |  |  |  |  |
| 1 Never Married 2 Marri   | If Yes, Give                            | No                                   | 1 ☐ Yes 21 No  | Specify:                               |  | Specify:                           |   |  |  |  |  |  |
| 3 ☐ Widowed 4 ☐ Divorced  | Year or Dates:                          |                                      |  |  |  | Cau                                | casian  |  |  |  |  |  |
| 15. Decedent<br>(Specify only highes  | s Education<br>t grade completed)       | 1 (0                                 | ecedent's Usual Occup<br>Give kind of work done                | during most of wo                      |  | 16b. Kind of Business/             | Industry  |  |  |  |  |  |
| Elementary/Secondary (0-12)   | College (1-4or 5                        | 5+)                                  | ife. DO NOT use retired  |  |  | 0 1 .                              |   |  |  |  |  |  |
|   | 5+                                      |                                      | Graphic Art  |  |  | Graphic                            | S   |  |  |  |  |  |
| 17. Father's Name (First, Middle,   | _ast)                                   |                                      |  | 18. Mother's Na                        | me (First, Middle, N                   | laiden Surname)                    |   |  |  |  |  |  |
| Per Olof Johan  | nes Dahlman                             | l                                    |  | Anna                                   | Elsa Bri                               | tta Sofia                          | Magnusson   |  |  |  |  |  |
| 19a. Informant's Name/Relationsh  | ip (Type. Print)                        | 19b. N                               | Mailing Address (Street  | and Number or F                        | lural Route Number,                    | City or Town, State, 2             | Zip Code)   |  |  |  |  |  |
| Barbaro Dahlı   | man / Siste                             | r 74                                 | 07 Holley A  | Ave; Tak                               | oma Park,                              | MD 20912                           |   |  |  |  |  |  |
| 20a. Method of Disposition  |   | 20b. Place of D                      | isposition (Name of crematory or other pla                     | ce)                                    | Date 2                                 | 20c. Location - City or            | Town, State   |  |  |  |  |  |
| 1 ☐ Burial 2 XCremation<br>4 ☐ Donation 5 ☐ Other (S)   |   | 1                                    | ncoln Crema  | i                                      | 20/2008                                | Brentwood                          | 1. MD   |  |  |  |  |  |
| 21. Signedure of Fluneral Service   |   | 0                                    | 22. Name and Addre   | ess of Facility                        | 20,2000                                | Brenewood                          | , 112   |  |  |  |  |  |
| (a. 1. )  | al Maril                                |                                      | Simple Tr  | ibute                                  | ke Rockw                               | ille, MD 2                         | 0852  |  |  |  |  |  |
| 23a. Part1. Enter the disease, or   | complications that cause                | the death. Do not                    |  |  |  |                                    | Approximate   |  |  |  |  |  |
| shock, or heart failure. List   | only one cause on each li               | ne.                                  | ,  | 3,                                     | . ,                                    |                                    | Interval Between<br>Onset and Death                 |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)  Colon Cancer  Due to (or as a consequence of):   |   |                                      |  |  |  |                                    |   |  |  |  |  |  |
| Due to (or as a consequence of):  |   |                                      |  |  |  |                                    |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (usease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |   |                                      |  |  |  |                                    |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  | Due to (or as                           | a consequence of)                    | ):   |  |  |                                    |   |  |  |  |  |  |
| that initiated events   | С                                       |                                      |  |  |  |                                    |   |  |  |  |  |  |
| resulting in death) Last  | Due to (or as                           | a consequence of)                    | 1:   |  |  |                                    |   |  |  |  |  |  |
|   | d                                       |                                      |  |  |  |                                    |   |  |  |  |  |  |
|   |   |                                      |  |  |  |                                    | -   |  |  |  |  |  |
| IF FEMALE:<br>23b. Was decedent pregnant  | 23c. If yes, outcome                    | pf pregnancy<br>2  Fetal death       | 3 □Ectopic pregnanc  | A.                                     |  | 23d. Date of de                    |   |  |  |  |  |  |
| in the past 12 months?<br>1 □ Yes 2 ☒No   | 4□Pregnant a                            |                                      | 5 ☐ Other (specify) _  | У                                      |  | Month                              | Day Year  |  |  |  |  |  |
| 9 □ Unknown   | 9□Unknown                               |                                      |  |  |  |                                    |   |  |  |  |  |  |
| Part II. Other significant condition  | ns contributing to death b              | out not resulting in t               | he underlying cause giv  | ven in Part I.                         | 23e. Did tob                           | pacco use contribute to            | the cause of death?                                 |  |  |  |  |  |
|   |   |                                      |  |  | 1 □ Ye                                 | es 2∐No 3∐Pi                       | robably 4 ⊠Unknow                                   |  |  |  |  |  |
|   |   |                                      |  |  | 242 14/2-                              | 24h Mora a                         | stoney findings available                           |  |  |  |  |  |
|   |   |                                      |  |  | 24a. Was ar<br>autops<br>perforr       | y prior to                         | utopsy findings available<br>completion of cause of |  |  |  |  |  |
|   |   |                                      |  |  |  | Tled? deatil?<br>2 X No 1 ☐ Yes    | 2 □ No  |  |  |  |  |  |
| 25. Was case referred to medical examiner?  |   |                                      |  |  | eath (Check only on                    | e)                                 |   |  |  |  |  |  |
| 1 ☐ Yes 2 🔀 No  | Hospital:<br>1 ☐ Inpati                 | ent 2 ☐ ER/Outp                      | atient 3 DOA   |  |  | ence 6 XOther (Spe                 | cify)Hospice  |  |  |  |  |  |
| 27. Manner of Death 1 X Natural 5 ☐ Pendin  | 28a. Date of Inju<br>(Month, Da         |                                      | ne of 28c. Inju  | ry at                                  | 28d. Describe ho                       | w injury occurred                  |   |  |  |  |  |  |
| 2 ☐ Accident investig   | gation                                  |                                      |  | Yes 2 □ No                             |  |                                    |   |  |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could r<br>4 ☐ Homicide determ  | zoe. Place of in                        | ury - At home, farn<br>tc. (Specify) | n, street, factory, office                                     |  | 28f. Location (St<br>City or Town      | reet and Number or R.<br>n. State) | ural Route Number,                                  |  |  |  |  |  |
| T LI TOTTION  | bullaling, e                            | io, (opoony)                         |  |  | Sily Si TOW                            | ,                                  |   |  |  |  |  |  |
|   | g Physician: To the best                |                                      |  |  |  |                                    |   |  |  |  |  |  |
|   |   | of examination and/                  |  |  |  |                                    |   |  |  |  |  |  |
|   | Examiner: On the basis of and manner st | ated.                                |  | 29d. Date signed (Month, Day, Year)    |  |                                    |   |  |  |  |  |  |
| (Check only 2 Medical   | and manner st                           | ated.                                | 29c. Licen   | se number                              | 2                                      | 9d. Date signed (Mon               | th, Day, Year)                                      |  |  |  |  |  |
| (Check ont) 2 ☐ Medical one)  29b. Signature and title of certifie  | and manner st                           | ated.                                |  | se number<br>0064615                   | 2                                      |                                    |   |  |  |  |  |  |
| (Check only 2 ☐ Medical one) 29b. Signature and title of certific   | no manner si                            | 7                                    | DC   |  | 2                                      | 9d. Date signed (Mont<br>5/04/2008 |   |  |  |  |  |  |
| (Check only 2 ☐ Medical one)  29b. Signature and title of certific of certific one of the certific one of | no manner si                            | death (Item 23a) (T                  | DC   | 0064615                                |  | 5/04/2008                          | 3   |  |  |  |  |  |

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = State 5-15-08 Registrar Amend#26 PerMed Dir Phys Poor Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day **Physician** Bennie Melvin Evans 2008 05 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Wasnington Prince George's County Fort Washington Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. 08/03/08/03/ 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F 577-56-2893 Director Georgia Usual Residence of Decedent r 28a-f show notified at 10c. City, Town or Location 10a State 10d. Inside City Limits Charles county Waldort MD 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2337 Ironwood Drive r than "natural", or items 23a or the Medical Examiner must be r USA 20601 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰ Yes 2 □ No If Yes, Give Year or Dates: 1964-1966 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BIACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "I Elementary/Secondary (0-12) College (1-4or 5+) (60 vernment rassport Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evans Benniel Drewer Jonah 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is n any Injury or other traum 2334 Ironwood Drive waldorf, mb 20601 Brenda Evans 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Lincoln memorial Cem 05/16/2008 Suitland, MD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bisanchi 814 upsnur St NW, Wash, DC 20011 21. Signature of Funeral Service 23a. Part1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CORINARY ATTERNY DISSASS Y R-5 /Medical Due to (or as a consequence of): Examiner DIABETTES MELLITYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to Cinas a ovi seguino di Examiner burial-transit HYPERTENSION and Due to (br as a consequence of) Box 68760. physician requires that the death certificate be Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months?
1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, by 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an cate has page 2 s autopsy perform certificate 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 I Nursing Home-1 Yes 2 No မှ 1 Inpatient 2OER/Outpatient 3 □ DOA 6 ☐Other (Specify) this idence 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Division To the Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide after within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D4769 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11711 Livingston Road Fort Washington, MD 20744 , mD Ronald C. Kinsey

Registrar

State

31. Date filed (Month, Day, Year)

MAY 1 5 2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 05 **Physician** Elford Т. Edwards 5:51P 09 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Laurel Regional Hospital Laurel Prince George's 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | 75 | Yrs. | Months Days Hours Min. | Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6. Sex **Funeral** 157M 2□ F 247-48-0148 Director 09 1932 15 South Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 X Yes 2 No D.C. Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20017 5035 11th. Street N.E. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc.
Black
Specify: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Offset Press Operator 12th.
17. Father's Name (First, Middle, Last) other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 is marked oth any Injury or other traumatic event Be Victoria Manning <u>Charles Edwards</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 5035 11th. St. N.E. Washington, D.C. 20017 Roland Edwards/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State MD. National Memorial 05-15-08 LAurel, MD. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 23a. Parfi. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirtly, or heart failure. List only one cause on each line. 4217 9th. St. N.W. Washington, D.C. 20011 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Collapse /Medical Due to (or as a consequence of): **Examiner** Ischemic Bowel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Small Bowel Obstruction physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical use as ed by the attending detached for use as IF FEMALE: If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_ in the past 12 months? Month Day Year 4☐Pregnant at time of death Yes 2 D No 9□Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 should be End Stage Renal Disease 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page Left Upper Extremity 1□ Yes 1 TYes 2X No 2 🔀 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 🔀 Inpatient 2 ER/Outpatient 3 DOA ပ္ this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2008 Doo52865 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) K. Michael Figars, MD. 12700 Goodloes Promise Drive, Bowie, MD. 20720 32. Registrar's Signature 31. Date filed (Month, Day, Year) State N Age Registrar MAY 1 5 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 5, 10e, 18 per inf 8881 7-1-08 vt State of Maryland / Department of Health and Mental Hygiene 2 1 8 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 4:08 Emily Elliott 9, 2008 May 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince George If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 □ M 2**X** F Feb. 27, 1929 Virginia Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 X Yes 2 No Prince George <u>Suitland</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3712 Denna Road 20746 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 XNo
If Yes, Give
Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Black 3 ★Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Senior Management Analyst Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Clark Janney Hill 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian C. Miller - Sister 3712 Dianna Rd. Suitland, MAryland 20746 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 □ Cremation 3 □ Removal from State May16, 2008|Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee 278 3831 GEorgia Ave . N.W. Wash., D.C. 20011 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) preumoma Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal dea as decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 2 Fetal death the past 12 months?
☐ Yes 2 X No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□ Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

MD

Director

Funeral

Completed by

**Funeral** 

Director

"natural", or items 23a or

other traumatic event, the Medical

the Maryland or 28a-f show a notified at

with ō

Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiene.

al Hygiene.

permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury or other tra

d

Baltimore, Maryland 21215-0036

Examiner attending physician and for use as the burial-transit an/Medical funeral director, Be P After this To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After Certification: filled in by the

law requires that the death certificate be executed

Box 68760,

Division or Vital Records, P.O.

| ysicianyly | 1F FEM<br>23b. W<br>in<br>1 [<br>9 [ |
|------------|--------------------------------------|
| ed by Fi   | Part II.                             |
| naidinos   |                                      |
|            |                                      |

Unknown 1 Yes 2 No 27. Manner of Death 1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

Medical

State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certif

25. Was case referred to medical

6 ☐ Could not be determined

5 Pending investigation

28a. Date of Injury (Month, Day Year)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? Injury

1 ☐ Yes 2 ☐ No

29c. License number

D28639

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Clinton, Md 20735

29d. Date signed, (Month, Day, Year) 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr.Jacques Zephirin

2 Medica

7501 Surratts Road Suite 303 gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1- State Amend Item 4a per phys. 5/21/08 dk Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 May 12, Year **Physician** Ellison 10:00 PM Gerd /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Monrovi a 4966 Fall Oaks Drive 4966 Tall Oaks Drive If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Months 125-32-3321 77 November 11, 1930 Norway Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mintal Hygiene. Important: If item 27 is manied other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Monrovi a Maryland Frederick Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21770 4966 Tall Oaks Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 11. Marital Status ☐Yes 2 Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: 2 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lilly Bjerch Haakon Stromberg 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12631 West Oak Drive, Mount Airy, Maryland 21770 Karen M. Seyler / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg, Maryland May 18, 2008 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Service Licens 106 East Church Street, Frederick, Maryland 21701 M01433 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) -CXE ENSIVE e -76/ -7 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the buria Box 68760 The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 5 Other (specify) ☐Yes 2 No P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? res 22 No 1 ☐ Yes 2 ☐ No 1 ☐Yes 101 Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific stely filled in by the funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2₽No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2170 176 2010564 32. Regierar's Signature 31. Date filed (Month, Day, Year) State DENGE . Registrar

# State of Maryland / Department of Health and Mental Hygiene, a p

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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| Physicia |
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| /Medica  |
| Examine  |
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Funera Directo

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modifical Examination in a training at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar DHMH 17 Rev 1/2001

|  | 1 - State<br>Registrar   | Cert                         | ificate of l   | Death                              |  | Reg. No.  | 2000                                     | 1/41  | O         |  |
|--|--|------------------------------|--|------------------------------------|--|---|--|---|-----------|--|
| ian<br>ical  | 1. Decedent's Name (First, Middle, Last)  RTHUR  C. FAST   |                              |  |                                    | 2. Date of De Montb                        | eath<br>Day   | 08                                       | 3. Time of Death                            | М         |  |
| ner  | 4a. Facility Name (If not institution, give street and number)  Mandarin Chesapeake House  |                              | 4b. City, Town, or<br>Harwood                                | Ē                                  |  | 4c. County of Death Anne Arundel                                  |  |   |           |  |
|  | 5. Social Security Number 102–18–6172 1. Age (In yrs. last 102–18–18–6172 1. Age (In yrs. last 102–18–6172 1. Age (In yrs. last 102– | t birthday) _<br>Yrs.        | If Under 1 Year<br>Months Days                               | If Under 24 H<br>Hours Mi          | rs. 8. Date of Bi<br>in. 2/23/1            | of Birth 9. Birthplace (State or Foreign Country) 3/1924 New York |  |   |           |  |
|  |  | Town or Loca                 | ation  |                                    |  |   | 10                                       | d. Inside City Limi                         | its       |  |
| Director   | MD Prince George's Bowie   | е                            |  |                                    |  |   | 1 ∐Yes 2ÅIN                              | 10  |           |  |
|  | 3509 Morlock Lane  |                              | 10f. Zip Code  | 20715                              |  | 10g. Citiz  | zen of What Coun<br>USA                  | ry?   |           |  |
| Funeral  | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?   | 13. W                        | as Decedent of H<br>Yes, specify Cuba                        | ispanic Origin?<br>an, Mexican, Pu | (Specify Yes or Nerto Rican, etc.)         | 0-  | 14. Race - Americ<br>Black, White, e     |   |           |  |
| b  | 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ No If Yes, Give Year or Dates: 1942—.  | 11                           | □Yes 2 <mark>X</mark> No                                     | Specify:                           |  |   | Specify:                                 | White                                       |           |  |
| Completed  | 15. Decedent's Education (Specify only highest grade completed)  | (Give ki                     | ent's Usual Occup<br>and of work done of<br>ONOT use retired | during most of v                   | vorking                                    | 16b. Kir  | nd of Business/Ind                       | ustry                                       |           |  |
| l mo   | Elementary/Secondary (0-12) College (1-4or 5+)   |                              | ce Office  | ,                                  |  | N.  | Y.C. Pol:                                | ice Dept.                                   |           |  |
| BeC  | 17. Father's Name (First, Middle, Last)  |                              |  | 18. Mother's N                     | lame (First, Middle                        |   |  |   |           |  |
| 10 E   | Charles A. Fast  |                              |  | Lill                               | iam Fey                                    |   |  |   |           |  |
|  | 19a. Informant's Name/Relationship (Type. Print)  Edith Fast / Spouse  | •                            | Address (Street  |                                    | Rural Route Numb                           |   | ` _ ` _ ` ` *                            | Code)                                       |           |  |
|  |  |                              | tion (Name of<br>atory or other place                        |                                    | Date                                       | ,   | cation - City or To                      | wn, State                                   |           |  |
|  |  | land V                       | /eteran':  | s Cem. !                           | 5/16/2008                                  | Cr  | ownsville                                | e, MD                                       |           |  |
|  | 21. Signature of Funeral Service Licensee  | }                            | Name and Address   | -                                  |  | Fune:<br>Le, M  | ral Home<br>D 20715                      |   |           |  |
|  | 23a. Part 1. Enter the disease, of complications that caused the death. I shock, or heart failure. List only one cause on each line.   |                              |  |                                    | 100  |   | 20,13                                    | Approximate<br>Interval Between             |           |  |
|  | Immediate Cause (Final disease or condition  | 7 a                          |  |                                    |  |   |  | Onset and Death                             |           |  |
|  | resulting in death)  Due to (or as a nsequen   | nce of):                     |  |                                    |  |   |  | -1  |           |  |
| <b>.</b>   | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequen  | 200 of):                     |  |                                    |  |   |  |   |           |  |
| Examiner   | cause. Enter Underlying Cause (Disease or injury   | ide oi).                     |  |                                    |  |   |  |   |           |  |
| Exa  | that initiated events c  | nce of):                     |  |                                    |  |   |  | -   |           |  |
| Medical  | d  |                              |  |                                    |  |   |  |   | _         |  |
|  | IF FEMALE: 23c. If yes, outcome of pregnant  | :y                           |  |                                    |  |   | 23d. Date of delive                      | rv  |           |  |
| Completed by Physician   | in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  1 □ Live birth 2 □ Fetal deal of the pregnant at time of the pregnant at time of the preg  | eath 3 🗌                     | Ectopic pregnanc<br>Other (specify) _                        | у                                  |  |   |  | Day Year                                    |           |  |
| y Ph   | Part II. Other significant conditions contributing to death but not resulting  | ng in the und                | lerlying cause giv   | en in Part I.                      | 23e. Did                                   | tobacco u   | se contribute to the                     | e cause of death?                           |           |  |
| q pa   | Ca live 2001   |                              |  |                                    | _   1□                                     | Yes 2   | □No 3.1 Prob                             | ably 4 ☐ Unkno                              | wn        |  |
| mplet  | Ca Colon 1995.   |                              |  |                                    | 24a. Was                                   |   | 24b. Were auto<br>prior to cor<br>death? | osy findings availal<br>npletion of cause o | ble<br>of |  |
| e Co   | 25. Was case referred to medical   |                              |  | 00.51 (5                           | 1 □ Yes                                    | 2 No  | 1 □Yes                                   | 2 □ No                                      |           |  |
| 00   | examiner?  | R/Outpatient                 | 3 🗆 DOA Oth  | 04.                                | Death <i>(Check only</i>                   |   | MAN<br>Specif                            | DRIN HOS                                    | TCE       |  |
| 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work?  28d. Describe how injury occurred Injury Work? |  |                              |  |                                    |  |   |  |   |           |  |
| catio  | 2 Accident investigation   |                              |  | Yes 2 □ No                         |  |   |  |   |           |  |
| ertifi   | 3 🗆 Suicide 6 🗆 Could flot be determined 28e, Place of Injury - At home building, etc. (Specify)   | e, farm, stree               | et, factory, office  |                                    | 28f. Location<br>City or To                | (Street and<br>wn, State)   | d Number or Rura<br>)                    | l Route Number,                             |           |  |
| Medical Certification: To  | 29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle Medical Examiner: On the basis of examination and manner stated.   | edge, death<br>n and/or inve | occurred at the tiestigation, in my o                        | me, date and pl<br>pinion, death o | ace, and due to the<br>ccurred at the time | e cause(s)<br>, date and  | ) and manner as s<br>I place, and due to | tated.<br>the cause(s)                      |           |  |
| Me   | 29b. Signature and title of certifier  |                              | 29c. Licens  | e number                           |  | 29d. Dat  | te signed (Month,                        | Day, Year)                                  |           |  |
|  | My Charl & Fent  | 74 51                        | <u> </u>   | 2/1                                | 138  | M   | oy 14,                                   | 2008  |           |  |
|  | 30. Name and address of person who of maleted cause of death (Item 23)   | 3a) (Type, P                 | HIGH I   | NAY                                | ANNAG                                      | 2045  | Moz                                      | 140)  |           |  |
| ate  | 31. Date filed (Month, Day, Year) 32. Registrar's Signard.   | مك                           |  |                                    |  |   |  |   |           |  |
| trar   |  |                              |  |                                    |  |   |  |   |           |  |

**Physician** /Medical **Examiner** Examiner Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran

permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygic Important: If Item 27 Is marked other any Injury or other traumatic event, tt

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at

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Funeral

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death with the Maryland

Maryland 21215-0036

Baltimore.

Division or Vital Records, P.O. Box 68760,

Physician/Medical

Completed by

Be

Certification: To

Medical

attending physician has this certificate filled in by To the Hospital
within 24 hours a
To the Funeral I completely

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

29b. Signature and title of certifier

Misson

27. Manner of Death

1 K Natural

2 Accident

4 ☐ Homicide

3 ☐ Suicide

determined

28a. Date of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

> 29c. License number 29505

29d. Date signed (Month, Day, Year) 05-10-08

50. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR., SALISBURY, MD 21801

Date filed (MAY Day Year) 2008

Registrar's Signature

Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day, Year **Physician** 3:00 PM Robert Francis Farrell mar 20 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's Hospital Leonardtown St. Mary's 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral ™** 2 □ F 219-32-2007 75 Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County "natural", or items 23a or 28a-f show dica Examiner must be notified at 1 ☐ Yes 2 No Director Maryland St. Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20618 United States Funeral 22483 Bushwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or ite 1 XYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **Black** Specify: ģ 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Delivery Floral 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Johnson Farrell Martha Louise Graves 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanie Bean / Sister P.O. Box 249 Leonardtown, Maryland 20650 injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Sacred Heart Cemetery 05/23/2008 Bushwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, PA. 21. Signature of Funeral Service Licensee M01206 Kyle S. Simons 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as pardiac or respiratory arrest, shock, or heart failure. List only one cause of the death of the cause o oximate val Between et and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 4 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infineduate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of). Examine The law requires that the death certificate be executed and Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part IJ, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ ₩o 24a. Was an certificate has Vital Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 5 After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident thours after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 29b. Signature and tille of certifier 29d. Date signed (Month, Day, Year) 2 Name and address of person Momas 31. Date filed (Month, Day, Year) MAY 2 2 2008

Registrar

| Please Type or Print in Black Indelible Ink | . Ensure All Copies Are Legible. |
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|                            |  |                          | 1 - For<br>State<br>Registrar  | State of Ma                                      | -   | Certificate of I                                    |   |                                    | 2008                          | 17419   |
|----------------------------|--|--------------------------|--|--|---|---|---|------------------------------------|-------------------------------|---|
|                            | Physicia   | ın                       | Decedent's Name (First, Middle, I  |  |   | CARRIO  |   | Date of Death<br>Month             | Day Year 7 2008               | 3. Time of Death  11:45 A <sup>M</sup>              |
| 7                          | /Medic   | al                       | LENORE  4a. Facility Name (If not institution, g   | BLANCHE  |   | FARRIS  | Location of Death                           | AY                                 | 4c. County of Deal            |   |
|                            | Examin   | er                       | ATLANTIC GENERA  |  |   | BERL  |   |                                    | WORCEST                       | ΓER   |
|                            | Funeral  |                          |  | Sex 7. Ag  | e (In yrs. last birth                             |   |   | Date of Birth (Month, Day, YEPT 6, | 9. Birt                       | thplace (State or Foreign<br>ountry)<br>ST VIRGINIA |
| Ш                          | Director   |                          | 233-90-9686  | 1□M 2ĂF  | 83 Y  | rs.   | S   | EPT. 6,                            | 1924 WES                      | ST'VIRGINIA   |
|                            | pud *  | 1                        | Usual Residence of Decedent  10a. State 10b. County  |  | 10c. City, Town                                   | or Location   |   |                                    |                               | 10d. Inside City Limits                             |
|                            | Aaryla<br>r aho  | ō                        | DELAWARE SUSS  | FY   |   | ELBYVILLE   |   |                                    |                               | 1 ☐ Yes 2 🛣No                                       |
|                            | 28a-   | rect                     | 10e. Street and Number   | 1.21   |   | 10f. Zip Code                                       |   | 100                                | g. Citizen of What Co         | ountry?   |
|                            | h with   | O is                     | 36648 OLD MILL   | BRIDGE ROA                                       | D   | 1   | 9975  |                                    | USA                           |   |
|                            | me 3   | ner                      | 11. Marital Status   | 12. Was Decedent<br>Armed Forces?                | Ever in U.S.                                      | 13. Was Decedent of H<br>If Yes, specify Cuba       | ispanic Origin? (Specin, Mexican, Puerto Ri | fy Yes or No-<br>can, etc.)        | 14. Race - Ame<br>Black, Whit |   |
| 21215-0036                 | s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at | by Funeral Director      | 1 ☐ Never Married 2 ☐ Married<br>3 🛣 Widowed 4 ☐ Divorced  |  |   | 1 ☐ Yes 2 🛣 No                                      | Specify:                                    |                                    | Specify: WI                   | HITE  |
| 5-0                        | 72 hc<br>natur   | Completed                | 15. Decedent's (Specify only highest   | Education<br>trade completed)                    |   | Decedent's Usual Occup<br>(Give kind of work done   | during most of working                      | 7                                  | 6b. Kind of Business          | /Industry   |
| 12                         | hen.   | mpi                      | Elementary/Secondary (0-12)  | College (1-4or                                   | 5+)   | life. DO NOT use retired HOMEMAKE                   |   |                                    | OWN HON                       | ΛE.   |
| 2                          | filed within Hygiene. other ther   | ပိ                       | 12<br>17. Father's Name (First, Middle, La   | st)  |   | HOPEPIARE   | 18. Mother's Name (                         | First, Middle, Ma                  |                               |   |
| an                         | Mental<br>Mental<br>arked o  | To Be                    | EARL   | C. F   | REEMAN  |   | AVIS  | HAI                                | MILTON                        |   |
| Maryland                   | 2 should<br>and Men<br>is marks  | ۲                        | 19a. Informant's Name/Relationship   | (Type, Print)                                    | 19b.  | Mailing Address (Street                             | and Number or Rural                         | Route Number,                      | City or Town, State,          | Zip Code)   |
|                            | and 2<br>aith a<br>127 is  |                          | BARBARA L. LYNCH   | /DAUGHTER  | 36  | 648 OLD MIL   |   | _                                  |                               |   |
| ore                        | of He<br>of He<br>fiter<br>roth  |                          | 20a. Method of Disposition<br>1 ☐ Burial 2 🛱 Cremation 3   | ☐Removal from State                              | 20b. Place of<br>cemetery                         | Disposition (Name of<br>r, crematory or other place |   |                                    | Oc. Location - City or        | Town, State   |
| Ĕ                          | Pag<br>ment<br>ant: f<br>ury o   |                          | 4 □Donation 5 □ Other (Spe   | city)  | CREMAT  | ORY OF DELM   | ARVA 5/8/                                   | 08 I                               | DELMAR, DE                    | ELAWARE   |
| Baltimore,                 | permit. Pages 1 and 2 sh<br>Department of Health and<br>Important: If Item 27 is n<br>any injury or other traum  |                          | 21. Signature of For ral Service Lie   | ensee Vac  |   | 22. Name and Addre                                  | •   | E, SELB                            | YVILLE, D                     | E. 19975  |
|                            | -  |                          | 23a. Part1. Enter the disease, or conshock, or heart failure. List or  | mplications that cause<br>ly one cause on each I | the death. Do n                                   | ot enter the mode of dyir                           | ng, such as cardiac or                      | respiratory arres                  | st,                           | Approximate<br>Interval Between                     |
| 12                         | Physician  | ,                        | Immediate Cause (Final disease or condition  | 0  | monca   |   |   |                                    |                               | Onset and Death                                     |
|                            | /Medical<br>Examiner   |                          | resulting in death)  |  | a consequence of                                  | f):   |   |                                    |                               |   |
| Н                          | Examiner   | <u>.</u>                 | Sequentially list conditions,  | b. Due to (or as                                 | a consequence of                                  | <i>(</i> 6).  |   |                                    |                               |   |
|                            | Ded<br>1sit  | nine                     | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | Due to (or as                                    | a consequence o                                   |   |   |                                    |                               |   |
|                            | tificate be executed<br>ig physicien end<br>as the burial-transit  | Examiner                 | that initiated events<br>resulting in death) Last  | c. Due to (or as                                 | a consequence of                                  | f):   |   |                                    |                               |   |
| 68760,                     | e be crisicien   | edicail                  |  | d  |   |   |   |                                    |                               |   |
|                            | tificati<br>g phy<br>as the  | _                        |  |  |   |   |   |                                    |                               | !   |
| Box                        | ne death certifi<br>the ettending I<br>thed for use as   | Completed by Physician/N | IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 ⊇ No  |  | of pregnancy<br>2  Fetal death<br>t time of death | 3 □Ectopic pregnance<br>5 □ Other (specify) _       | y   |                                    | 23d. Date of de<br>Month      | elivery<br>Day Year                                 |
| P.0                        | = > 0  | Phy                      | 9 Unknown  |  | and not requisite the                             | the undertains                                      | on in Rad I                                 | 23a Did tob                        | acco use contribute t         | to the cause of death?                              |
|                            | w requires that<br>been signed b<br>should be deta   | ed by                    | Part II. Other significant condition   | s contributing to death i                        | out not resulting in                              | the underlying cause give                           | en in Part I.                               | 1 🗌 Yes                            | _/                            | Probably 4 Unknown                                  |
| Division of Vital Records, | elaw<br>hasb<br>je 2 si  | ompiet                   |  |  |   |   |   | 24a. Was an autopsy perform        | ed? prior to death?           | autopsy findings available completion of cause of   |
| ita                        |  | 0                        | 25. Was case referred to medical   |  |   |   | 26. Place of Death                          |                                    |                               |   |
| <b>&gt;</b>                | \$ .g. 5   | To B                     | examiner?<br>1   Yes 2   Mo  | Hospital: 1 Pinpati                              | ent 2 ER/Out                                      | tpatient 3 DOA                                      | ner: 4 🗌 Nursing Hom                        | e 5 🗆 Resider                      | nce 6 Other (Sp.              | ecify)  |
| 0 [                        | E # E  |                          | 27. Manner of Death 1 ☑Natural 5 ☐ Pending   | 28a. Date of Inj<br>(Month, D.                   | ury 28b. T  | ime of 28c. Injury Wo                               |   | Bd. Describe how                   | w injury occurred             |   |
| Sio                        | tendin<br>leath.<br>tor: Af<br>the fur   | cati                     | 2 Accident investigated investigated and accident according to the second accident a | t be   | in Albana fa                                      |   | Yes 2 □No                                   | 9f Location /Str                   | eet and Number or F           | Rural Route Number                                  |
| Σ                          | or At<br>efter c<br>Direc<br>in by   | Certification:           | 4 Homicide determin  | ad 286. Place of in                              | tc. (Specify)                                     | rm, street, factory, office                         |   | City or Town,                      | State)                        | TUTAL TODIO TOTAL                                   |
| _                          | To the Hospital or Attendi<br>within 24 hours effer death.<br>To the Funeral Director: A<br>completely filled in by the fu   |                          | 29a. Certifier 1 Certifying  | Physician: To the bes                            | t of my knowledge                                 | , death occurred at the ti                          | me, date and place, a                       | nd due to the ca                   | use(s) and manner a           | as stated.  |
|                            | ns Ho  | Medicai                  | (Check only 2 Me See E   | aminer: On the basis<br>and manners              | of examination and                                | d/or investigation, in my                           | opinion, death occurre                      | d at the time, da                  | te and place, and du          | ue to the cause(s)                                  |
|                            | To th<br>within<br>To th<br>comp   | Me                       | 29b. Signature and title of certifier  |  |   | 29c. Licens   | se number                                   | 29                                 | d. Date signed (Mor           | nth, Day, Year)                                     |
|                            | 2 -1   |                          | > <td>/ N</td> <td>40</td> <td>1 05</td> <td>3612</td> <td>S</td> <td>17/08</td> <td></td>   | / N  | 40  | 1 05  | 3612  | S                                  | 17/08                         |   |
|                            | JB1  |                          |  | Saler 9  | death (Item 23a) (                                | Type, Print)  a ITh way                             | Dr Berl                                     | in MO                              | 21811                         |   |
|                            | Sta  | ite                      | 31. Date filed (Month, Day, Year)  | 32. Reg  | rar's Signature                                   | 1.12  |   |                                    | fa:                           | *****   |
| 1                          | Regist   | af                       | MAY 0  | 9 2008   | we D  | Asser   |   |                                    |                               |   |

|     |            |  |                 | 1- State of Maryland / Department / Department / Departmen | artment of Health and Mer<br>rtificate of Death                 | ntal Hygier                         | 2988                           | 17420  |
|-----|------------|--|-----------------|--|---|-------------------------------------|--------------------------------|--|
|     |            |  |                 | Decedent's Name (First, Middle, Last)  |   | Date of Death                       | 10.                            | 3. Time of Death                               |
| _   |            | Physici  |                 | TACK THOUGH FLORIO   |   | Month I                             | 20 2009                        | 0938,4   |
|     |            | /Medic<br>Examir   |                 | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death                            | 1-1111                              | 4c. County of Death            | 1000   |
|     |            |  |                 | Harford Memorial Hospital  | Havre de Grace  |                                     | Harfor                         | a  |
|     |            | Funeral  |                 | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  | If Under 1 Year If Under 24 Hrs. 8.                             | Date of Birth                       | 9 Birthr                       | lace (State or Foreign                         |
|     |            | Director   |                 | 215–32–9062 <sup>1⊠M 2□F</sup> 71 Yrs.   | Months Days Hours Min.  | (Month, Day, Ye 0/27/193            | 86 Mary                        |  |
|     |            | p ×  |                 | Usuel Residence of Decedent           10a, State         10b, County         10c, City, Town or Lo   | action  |                                     |                                | 04 1-14-05-11-3-                               |
|     |            | eho.   | 5               |  |   |                                     |                                | 0d. Inside City Limits  ↓□Yes 2 □ No           |
|     |            | ter death with the Marylar<br>iteme 23a or 28a-f ehow<br>irer missi be notified at   | Director        | MD Harford Aberde  |   |                                     | 077                            |  |
|     |            | with a or  |                 |  | 10f. Zip Code   | 10g.                                | Citizen of What Cou            | ntry ?   |
|     |            | eath   | eral            | 2 Aberdeen Avenue  11. Marital Status  12. Was Decedent Ever in U.S. 13. V   | 21001  Was Decedent of Hispanic Origin? (Specify                | Voe or No                           | U.S.A.<br>14. Race - Americ    | can Indian                                     |
|     | 10         | ter dea  | Funeral         |  | f Yes, specify Cuban, Mexican, Puerto Ric                       | an, etc.)                           | Black, White,                  |  |
|     | 93         | urs af   | þ               | 3 □ Widowed 4 □ Divorced ff Yes, Give Year or Dates: Marines   | 1 ☐ Yes 2X No Specify:  |                                     | Specify: Whi                   | te   |
|     | 21215-0036 | filed within 72 hours after death with the Maryland<br>Hygiene.<br>uther then "naturel", or iteme 23a or 28a-f ehow<br>inth, the Medical Examinar must be notified at  | Completed       | 15. Decedent's Education 16a. Decedentia | dent's Usual Occupation   | 16b                                 | . Kind of Business/In          | dustry   |
|     | 2          | l within 7<br>iene.<br>r then "n   | ם               | Efementary/Secondary (0-12) College (1-4or 5+)   | kind of work done during most of working<br>DO NOT use retired) |                                     |                                |  |
|     |            | e filed with<br>al Hygiene.<br>other thei  | S               |  | facturing   | Aut                                 | comobiles                      |  |
| Z   | pu         | be file<br>ital Hyg<br>id othe<br>event,   | Be              | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name (F  | irst, Middle, Maid                  | len Sumame)                    |  |
| A   | Σ          |  | ၉               | Frederick Florio   | Rose Fra  |                                     |                                |  |
| 00  | Maryland   | Pages 1 end 2<br>nent of Health a<br>nut: if item 27 i   | . 1             |  | ng Address (Street and Number or Rural R                        |                                     |                                | Code)  |
| 4   |            |  |                 | Louise Florio (Spouse) 2 A 20a. Method of Disposition 20b. Place of Dispo  |   | deen, MD                            | 21001<br>Location - City or To | num State                                      |
| 39  | 2          |  |                 | N Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crem   | natory or other place)  | 46                                  |                                |  |
| 9   | Baltimore, |  | 1               |  | esby. Cemet. 5/22/0  Name and Address of Facility               | o ADC                               | rdeen, Ma                      | ryıand   |
|     | B          | permit. Departr Imports eny inje   | 8 0             | I Is Alpalla I walnung   | Tarring-Cargo Funer   | al Home,                            | P.A.                           |  |
|     |            |  |                 | 23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.   | er the mode of dying, such as cardiac or re                     | 21001-3 espiratory arrest,          | 399                            | Approximate                                    |
|     |            | Physician  |                 | fmmediate Cause (Final   | Coloul  |                                     |                                | Interval Between                               |
|     |            | /Medical   |                 | disease or condition resulting in death)  Due to (or as a consequence of)  | LOUN  |                                     |                                | PROVITO  |
|     |            | Examiner   |                 | Convention to the condition  |   |                                     |                                |  |
|     |            | D =  | ner             | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.   |   |                                     |                                |  |
| OS  |            | ecute<br>and<br>trans  | Examiner        | Cause (Disease or injury that initiated events c   | -   |                                     |                                |  |
| 0   | 60,        | cate be executed<br>physicien and<br>the burial-transit  |                 | resulting in death) Last Due to (or as a consequence of):  |   |                                     |                                |  |
| 2   | 8760,      |  | dicai           | d  |   |                                     |                                |  |
| 10  | ox 6       | ding<br>se as  | /Me             | IF FEMALE: 23c. If yes, outcome of pregnancy   |   |                                     | 221 2                          |  |
| (7) | B          | atter<br>I for L   | clar            | in the past 12 months?   | Ectopic pregnancy Other (specify)                               |                                     | 23d. Date of delive<br>Month   | Day Year                                       |
|     | P.O.       | thet the death certifi<br>ied by the attending I<br>deteched for use as  | hysi            | 9 Unknown  |   |                                     |                                |  |
| 0   |            | res the<br>igned I<br>be det   | by Physician/Me | Part II. Other significant conditions contributing to death but not resulting in the un  | nderlying cause given in Part I.                                | 23e. Did tobaco                     | o use contribute to t          | ne cause of death?                             |
| -   | Records,   | w require<br>been sig<br>should b  | ed              | HYPERTENSIAM, VIABE  | TES (NON-INSULI DEP)  | 1 🗆 Yes                             | 2₽No 3□ Prot                   | ably 4 Unknown                                 |
| 8   | ည်<br>ရ    | e law re<br>has beo<br>je 2 sho  | Completed       | /  | • /   | 24a. Was an                         | 24b. Were auto                 | psy findings available<br>mpfetion of cause of |
| 10  | Ä          | The rate has page  | E               |  |   | autopsy<br>performed<br>1 ☐ Yes 2 ☑ | ? death?                       | mpretion of cause of                           |
| 1   | Vital      | icien: Th<br>certificate<br>ector, pag   | Bec             | 25. Was case referred to medical examiner?   | 26. Place of Death (C   |                                     |                                | <b>32110</b>                                   |
| ( . | of V       | Physic<br>this ce<br>al dire   | ၉               | 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien  | t 3 DOA Other: 4 Nursing Home                                   | 5 Residence                         | 6 ☐Other (Special              | y)   |
| 1   |            | fing Physicien:  After this certific funeral director,   | <br>            | 27. Mann Death 28a. Date of Injury 28b. Time of (Month, Day Year) 1 Natural 5 □ Pending (Month, Day Year) 1 The of Injury  | Work?   | . Describe how in                   | njury occurred                 |  |
| X   | Sio        | Attendi<br>death.<br>ctor: A   | cat             | 2 Accident investigation 3 Suicide 6 Could not be  | M 1 Yes 2 No  |                                     |                                |  |
| Ac  | Division   | or A<br>after<br>Direction by  | Certification:  | 4 Homicide  4 Homicide  4 Homicide  4 Homicide  4 See Place of Injury - At home, farm, str. building, etc. (Specify)   | eet, factory, office 28t.                                       | City or Town, St                    | and Number or Rura<br>ate)     | M Route Number,                                |
| 0   | _          | To the Hospital or Attending Physicien: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely illed in by the funeral director, page 2 should be deteched for use as |                 | 29a. Certifier Certifying Physicien: To the best of my knowledge, death  | occurred at the time, date and place, and                       | due to the cause                    | e(s) and manner as a           | tated  |
| 1   |            | To the Hos<br>within 24 h<br>To the Fur<br>completely  | Medical         | (Check only one) 2 Medical Examiner: On the basis of examination and/or invane) and manner stated.   | vestigation, in my opinion, death occurred                      | at the time, date                   | and place, and due to          | the cause(s)                                   |
|     |            | To the within 2 To the complet   | M               | 29b. Signature and title of Certified  | 29c. License number   | 29d.                                | Date signed (Month,            | Day, Year)                                     |
|     |            |  |                 | • WWW  | D40922  | 1                                   | 195212                         | 2008   |
|     |            |  |                 | 30. Name and address of person who completed cause of death (item 23a) (Type,  | Print)  | 16 -                                | A.                             | / _  |
|     |            |  |                 | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | rolly Micon AVI   | MAVIP                               | deltem/                        | 1D   |
|     |            | Sta<br>Registr   |                 | 31. Date filed (Month, Day, Year)  MAY 2 9 2008  32. Registrar's Signature   | all I   |                                     |                                |  |

State

OCMF 2006

Registra DHMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2008

Ling Li, MD

31. Date filed (Month, Day, Year)

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

May 18, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death May 11, 2008 **Physician** 6:56 p Eddie Dean Gray /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Emmitsburg Frederick 16626 Old Emmitsburg Road If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Apr 6, 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 1960 Pennsylvania 205-44-7996 48 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10h County show r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at Emmitsburg Maryland Frederick 1 ☐Yes 2 No Director 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code 21727 16626 Old Emmitsburg Road by Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. white 3 ☐ Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) e filed within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Construction Laborer permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 Is marked other any Injury or other traumatic event, <u>11</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nancy Lee Baker Warren E. Gray 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16626 Old Emmitsburg Road, Emmitsburg, MD 21727 19a. Informant's Name/Relationship (Type. Print) Catherine Pittinger, friend Baltimore, 20h. Place of Disposition (Name of Scheme Pry, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carroll Crematory Winfield, MD 5/13/2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic 22. Name and Address of Facility Myers-Durboraw Funeral Home 210 W. Main Street, Emmitsburg, MD 21727 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a, Part1 Immediate Cause (Final disease or condition resulting in death) **Physician** 12 Extensive 100 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical for use as the attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No. been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an page 2 s autopsy perform certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home See Residence 6 Other (Specify) 1 Yes 20 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: or Attending 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

WIL

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

190504

MAY 13

Registrar DHMH 17 Rev 1/2001

State

29c. License number

D14626

and manner stated.

501 00 1

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

2008

08-03451 Dennis Glass

# Amended Item 16a per F.D. 05/12/2008 Carroll Co., wjl Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|  |                | 1- For State<br>Registrar   |   | Certifi                     | icate of                     | Death  |                              |                            | Re                                | eg. No. 2                        | 00                         | 8 1                                 | 742      |
|--|----------------|---|---|-----------------------------|------------------------------|--|------------------------------|----------------------------|-----------------------------------|----------------------------------|----------------------------|-------------------------------------|----------|
| Physicia<br>dical Exami  | ın/            | 1. Decedent's Name (First, Middle, L<br>Dennis Alle   | 2. Date of Month May 5.   |                             |                              |  |                              |                            | h<br>Dav Ye                       | ar                               | 3. Time of Dea<br>1730 hrs |                                     |          |
| tre ,  |                | 4a. Facility Name (if not institution, g<br>9423 Rocky Ridge Road   |   |                             | 4                            | b. City, Town, o<br>Rocky Ride                               |                              | of Death                   |                                   | 4c. County<br>Frederic           |                            |                                     |          |
| Funeral<br>Director  |                |   |   | (In yrs. last b<br>51       | oirthday)<br>Yrs.            | If Under 1 Ye Months Da                                      |                              | 1.40                       |                                   | th(MM/DD/YYY<br>3, 1956          | Foreig                     | hplace (State of<br>Penna<br>Intry) | ır.      |
| Maryland<br>28a-f show any<br>d.at once.   | tor            | Usual Residence of Decedent  10a. State 10b. County  Maryland Freder  10e. Street and Number  | 1   | 0c. City, Tov               | wn or Location               |  |                              | Rock                       | y Rido                            |                                  | lhat Cour                  | 10d. Inside Ci                      |          |
| th the Maryland<br>23a or 28a-f sho  | Director       | 9423 Rocky Ridge  | Road  |                             |                              | 10f. Zip Code  | 217                          | 78                         | 10g. Citizen of What Coun         |                                  |                            |                                     |          |
| 15-0036<br>filed within 72 hours after death with the Maryland<br>1 Hygiene.<br>ed other than "natural", or items 23a or 28a-f she<br>i, the Medical Examiner must be polified at once   | by Funeral     |   | ed If Yes, Give Year or Dates:  | No                          | 1                            | S Decedent of Hes, specify Cube                              | n, Mexican, o specify:       | , Puerto Ri                | can, etc.)                        | Whi<br>Specify:                  | te, etc.<br>W              | can Indian, Bla<br>hite             | ck,      |
| 5-0036<br>led within 72 hours<br>Hygiene.<br>other than "natu<br>the Medical Exan  | Completed      | 15. Decedent's Education (Specify<br>Elementary/Secondary (0-12)  | College (1-4 or 5-  | S-                          | eİİİ <sup>ng</sup> Ei        | r's Usual Occup<br>in <b>1 oyed</b><br>in 1 oyed<br>imployed | Conc                         | acto:                      | er-                               | <u> </u>                         | struc                      | tion                                |          |
| O 3 2 2 2 5  | Be Co          | 17. Father's Name (First, Middle, La<br>James M. Glas   |   |                             |                              |  |                              |                            | irst, Middle.<br>e Shri           | Maiden Surnam<br>Ner             | e)                         |                                     |          |
| MD 21<br>12 should<br>th and Me<br>17 is ma<br>umatic ev   | 2              | 19a. Informant's Name/Relationship (Type, Print )  Paula C. Glass, wife  19b. Mailing Address (Street and Number or Rural Route Number, City  40 N. Church Street, Waynesboro,  |   |                             |                              |  |                              |                            | -                                 |                                  |                            |                                     |          |
| s l and free liften  |                | 20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other Spec   |   | e Sout                      | nthory or oth                | Cremato  | ry                           | 5/09                       | )<br>2008                         | 20c. Location Winfi              | eld,                       | MD                                  |          |
| Baltimo<br>permit. Page<br>Department o<br>Important:<br>injury or oth   |                | 21. rignature of Funeral Survice Li   | Julion  |                             | 22. N<br>21                  | ame and Addre  | ss of Facility<br>in St      | Mye<br>reet,               | rs—Dur<br>Emmit                   | boraw F<br>sburg,                | uner<br>MD 2               | al Home<br>1727                     | 9        |
| Physician<br>/Medical  | 7              | 23a. Part I. Enter the disease, or co<br>failure. List only one cause on<br>Immediate Cause (Final disease  |   |                             |                              |  | g, such as c                 | ardiac or re               | espiratory arr                    | est, shock, or h                 | eart                       | Approximate<br>Between O<br>Dea     | nset and |
| xaminer  |                | or condition resulting in death)  Sequentially list conditions,   | Due to (or as a consect   |                             |                              |  |                              |                            |                                   |                                  |                            |                                     |          |
|  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):   |   |                             |                              |  |                              |                            |                                   |                                  |                            |                                     |          |
| xecuted n and - transit  | al Ex          | d.  UNPENDED  IX AMENDED Item 16a per F.D. 05/12/2008 Carroll Co., wj1  |   |                             |                              |  |                              |                            |                                   |                                  |                            |                                     |          |
| 68760,<br>certificate be executed<br>nding physician and<br>se as the burial - transi  | Medical        | UNPENDED  IF FEMALE:  | X AMENDED Ite   |                             |                              | F.D. 05/   |                              |                            |                                   | Co., W                           |                            | ,                                   |          |
|  | Physician/     | 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown   | 1 Live birth 4 Pregnant at t  ym 9 Unknown                                  | ime of death                | -=                           | tal death 3<br>ner (Specify)                                 | Ectopio                      | c pregnanc                 | :у                                | Month                            |                            | Day `                               | Year     |
| rres that the signed by I be detache   | ρ              | Part It. Other significant condition  | s contributing to death   | but not resul               | Iting in the u               | nderlying cause  | given in Pa                  | art I.                     |                                   | obacco use con<br>s 2 No 3       |                            |                                     |          |
| ision of Vital Records, P.O. Box 68' Attending Physician: The law requires that the death certificate.  ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as | Completed      |   |   |                             |                              |  |                              |                            | 1 Yes                             | osy<br>ormed?                    |                            | topsy findings<br>completion of c   |          |
| of Vital ng Physician: After this certif neral director,   | o Be (         | 25. Was case referred to medical examiner?  1 ✓ Yes 2 No  | Hospital: 1 Inpatier  | nt 2 ER                     | R/Outpatient                 |  | Other                        | <del></del>                | ly one)<br>Home 5                 | Residence 6                      | <b>✓</b> Other             | r: Scene                            |          |
| ion of \ itending Phy leath. tor: After the  | $\vdash$       | 27. Manner of Death  1 Natural 5 Pending  |   | y 28<br>ar)                 | Bb. Time of I                | ′′   _   | ury at Work                  |                            | 28d. Describe how injury occurred |                                  |                            |                                     | -1-1-    |
| Division  Hospital or Attendi A hours after death. Funeral Director: A   | Certification: | 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Rou or Town, State) |   |                             |                              |  |                              |                            |                                   | iral Route Num                   | iber, City                 |                                     |          |
| To the Hosp<br>within 24 ho<br>To the Fune<br>completely f   | Medical C      | 29a. Certifier 1 Certifying Physone) 2 Medical Exami  | sician: To the best of my<br>ner:On the basis of exam<br>any manner stated. | knowledge,<br>ination and/o | death occur<br>or investigat | red at the time,<br>ion, in my opinio                        | date and pla<br>on, death oc | ace, and di<br>curred at t | ue to the cau<br>he time, date    | se(s) and mann<br>and place, and | er as stat<br>due to th    | ed.<br>e cause(s)                   |          |
| WIL  | ğ              | 29b. Signature and title of certifier   | 1/Cm  |                             |                              | 1  | .M.E.                        |                            |                                   | 29d. Date sig                    |                            | nth, Day, Year)                     |          |
|  |                | 30. Name and address of person will David Fowler M.D. Ch  | no completed cause of de<br>nief Medical Exami                              |                             | ,                            | reet, Baltim   | ore, MD                      | 21201                      |                                   |                                  |                            |                                     |          |
| St<br>Regist   | ate<br>rar     | 31. Date filed (Month, Day, Year) MAY 1 2   | 32. Registrar<br>2008   | s Signature                 | K So                         | ack s  |                              |                            |                                   |                                  |                            |                                     |          |
| DHMH 17 Rev 1/2  | 001            |   | 7,000   | (                           | ORIGINA                      | L  |                              |                            |                                   |                                  |                            |                                     |          |

08-03844 Myles K. Gibson

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2008 17424 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day May 20, 2008 0449 hrs Medical Examiner GIBSON 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or ForeignMARYLAND Date of Birth (MM/DD/YYYY) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Hours Months Days 216-33-4619 APRIL 14\*1986 Director Country) 1 X M 2 F 22 Yrs Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 No SILVER SPRING 28a-f show marked other than "natural", or items 23a or 28a-f sho c event, <u>the Medical Examiner must be notified at once.</u> MONTGOMERY MD 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USA 20904 12614 BILLINGTON ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 2 Married 2 Yes BLACK 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: ⋧ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) it. Pages 1 and 2 should be filed within 72 hou trenet to Health and Mental Hygiene, tant: If liene, 27 is marked out or other trees. Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) PRIVATE STUDENT 2 yrs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PITCHER EVELYN FRANK GIBSON Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090419a, Informant's Name/Relationship (Type, Print) 12614 BILLINGTON ROAD SILVER SPRING, MARYLAND FRANK GIBSON/FATHER
20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State GATE OF HEAVEN 5/27/2008 SILVER SPRING, MD Donation 5 Other Specify permit. J Departm Importa injury o 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME Signature of Funeral Service License 7474 LANDPVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medical Death Asthma Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): īne cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical X UNPENDED attending physician or use as the burial **^\#250E**,27,perME, G880 6/5/08 TI Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o Š 1 Yes 2 No 3 Probably 4 Unknown م Completed Records, s been s 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? certificate has performed' ✓ Yes 2 No 1 🗸 Yes Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Other<sub>4</sub> DOA Inpatient 2 🗸 ER/Outpatient 3 Nursing Home 5 Residence 6 Other: this 1 🗸 Yes After the 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 X Natural 1 Yes 2 No 5 Pending Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To he best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number May 21, 2008 O.C.M.E. ompleted cause of death (Item 23a) 30. Name and address of person who Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201 **OCME** Mary G. Ripple MD. 32. Registrar's Signature State 2008<sup>ar)</sup> Registrar

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

| arol Mona Hai   |                | State of Maryland / Department of Healt  - For State  Certificate of Death   | h and Menta                     | l Hygiene                                | 2008   | 1742                                    |  |
|---|----------------|--|---------------------------------|--|--|---|--|
| Physici   |                | Registrar  1. Decedent's Name (First, Middle,Last)   |                                 | Reg. No<br>2. Date of Death              | э.   | ime of Death                            |  |
| ledical Exam  | iner           | CAROL MONA HAINES  |                                 | Month Day<br>May 7, 2008                 |  | 012 hrs                                 |  |
|   |                | 4a. Facility Name (if not institution, give street and number) 4b. City, T 1701 Gruenther Avenue 4b. City, T Rocky                             | own, or Location of I           |  | sc. County of Death<br>Montgomery            |   |  |
| Funeral<br>Director   |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Unde Months 7. Age (In yrs. last birthday) Months                           | 1 Year If Under 2<br>Days Hours | 24Hrs. 8. Date of Birth (MN FEB 20, 1    | WDD/YYYY) 9. Birthplan<br>Foreign<br>Country | ce (State or<br>)New York               |  |
| , h   |                | Usual Residence of Decedent  | <u> </u>                        |  |  |   |  |
| faryland<br>28a-f show any<br>Latonce.  | or             | 10a. State 10b. County 10c. City, Town or Location 10m 10m 10m 10m 10m 10m 10m 10m 10m 10m   |                                 |  |  | . Inside City Limits  X Yes 2 No        |  |
| , MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland teath and Mental Hygiers and are are are are are are are are are are  | Director       | 10e. Street and Number10f. Zip1701 Gruenther Avenue208   |                                 |  | itizen of What Country?<br>Lted States       |   |  |
| with with ms 23s  |                |  |                                 | ? ( Specify Yes or No-                   | 14. Race - American I                        | ndian, Black,                           |  |
| r death<br>or ite   | Funeral        | 1 Yes 2 X No   | Cuban, Mexican, F               | ruerto Rican, etc.)                      | White, etc.                                  |   |  |
| s after<br>oral",   | by             | 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual C        | X No specify:                   | ad af wards along                        | Specify: White                               | ·                                       |  |
| 2 hour<br>"natu   | Completed      |  | king life. DO NOT us            |  | . Kind of Business/Indus                     | ury                                     |  |
| 036<br>thin 7<br>ne.  | nple           | 6 Public Heal  | th Consul                       | ltant   W                                | VESTAT                                       |   |  |
| 5-0<br>Hygier<br>Other  |                | 17. Father's Name (First, Middle, Last)  |                                 | Name (First, Middle, Maide               | n Surname)                                   |   |  |
| 21215-0036 uld be filed within 7 Mental Hygiene. marked other than  | Be             | Frederick Charles Haines   |                                 | red F.                                   | Fink   |   |  |
| Baltimore, MD 21215-0036 Departit. Pages 1 and 2 should be filed within 72 hours after beatment of Health and Mental Hygiewith Infinem 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner   | 2              |  | •                               | #5-B, New Y                              | •  | •                                       |  |
| and 2 Jealth item 2   |                | 20a. Method of Disposition 20b. Place of Disposition (Nam  | e of cemetery,                  |  | c. Location - City or Tow                    |   |  |
| Baltimore,<br>pernit. Pages 1 ar<br>Department of He<br>Important: If ite   | ,              | Burial 2 Cremation 3 Removal from State Riverdale Park   |                                 | 5/12/2008 Ri                             | iverdale Pa                                  | rk. MD                                  |  |
| altin<br>nit. P<br>partme<br>portan   | d              | 4 Donation 5 Other Specify: Crematory 21. Signature of Funeral Service Licensee 22. Name and   |                                 | ary Service,                             |  |   |  |
| Per Per Initial   |                | Brus Miller MO1508 933 Gi  | leau Morti<br>.st Ave.,         | lary Service,<br>LL, Silver S            | P.A.<br>Spring, MD                           | 20910                                   |  |
| Physician   |                | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of<br>failure. List only one cause on each line. | f dying, such as car            | diac or respiratory arrest, s            | hock, or heart A                             | oproximate Interval<br>etween Onset and |  |
| /Medical<br>Examiner  | 8              | Immediate Cause (Final disease a. Complications of Morbid Obesity  |                                 |  |  | Death                                   |  |
|   |                | or condition resulting in death)  Due to (or as a consequence of):   |                                 |  |  |   |  |
|   | Jer            | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |                                 |  |  |   |  |
|   | Examiner       | Citizense or injury that initiated events resulting in death) Last Due to (or as a consequence of):  |                                 |  |  |   |  |
| e executed<br>clan and<br>ial - transit   |                | d.   |                                 |  |  |   |  |
| be execut<br>ician and<br>irial - trai  | dical          | UNPENDED AMENDED   |                                 |  |  |   |  |
| lox 68760, leath certificate be attending physicifor use as the buri  | Physician/Me   | IF FEMALE: 23c. If yes, outcome of pregnancy   | 2                               |  | 3d. Date of delivery                         | Vasa                                    |  |
| x 68<br>h certi<br>tending<br>use as  | iciar          | past 12 months?    4   Pregnant at time of death   5   Other (Spec   |                                 | pregnancy                                | Month Day                                    | Year                                    |  |
| Box<br>e death c<br>the atten   | hys            | 1 Yes 2 No 9 V Unknown g Unknown   |                                 |  |  |   |  |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death. To the function: After this certificate has been signed by the attending physici completely filled in by the funeral director; page 2 should be detached for use as the buni | by             | Part II. Other significant conditions contributing to death but not resulting in the underlying  | cause given in Part             |  | o use contribute to the o                    | p                                       |  |
| of Vital Records, ng Physician: The law requir the this certificate has been s meral director, page 2 should I  | Completed      |  | 24a. Was an autopsy             |  |  |   |  |
| eco<br>he law<br>te has   | ш              |  |                                 | performed                                | ? death?                                     | 2 No                                    |  |
| tal Recian: The certificate ector, page   | Be C           |  | 6.Place of Death (C             |  |  |   |  |
| Vita<br>hysicia<br>this ca<br>I direc   | To B           | examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 D  | OA Other I                      | Nursing Home 5 Resid                     | dence 6 🗸 Other: Sco                         | ene                                     |  |
| of Vital Rec<br>ling Physician: The l<br>After this certificate I<br>funeral director, page   | L:             | 1 Motural (Month, Day, Year)   | 8c. Injury at Work?             | 28d. Describe how in                     | njury occurred                               |   |  |
| Division tal or Attendir rs after death. al Director: A   | Certification: | 2 Accident Investigation   | 1 Yes 2 N                       |  |  |   |  |
| Divisior pital or Attencours after death erral Director:  | rtilij         | 3 Suicide 6 Could not be determined (Specify)  | office building, etc.           | 28f. Location (Street<br>or Town, State) | t and Number or Rural F                      | Route Number, City                      |  |
| Lospita<br>Hours<br>unera<br>ly fille   |                | 29a. Certifier   | time data and alass             | o and due to the source(a)               | and manner as stated                         |   |  |
| To the Hospital<br>within 24 hours.<br>To the Funeral   | Medical        | (Check only one)  2 Medical Examiner:On the basis of examination and/or investigation, in my   |                                 |  |  | use(s)                                  |  |
| To Voit   | Me             | and manner stated.  29b. Signature and title of certifier  29c.  | License number                  | 290                                      | d. Date signed (Month,                       | Day, Year)                              |  |
| 10  |                | Poto de Palliero   | O.C.M.E.                        | M  | ay 8, 2008                                   |   |  |
| (10)  |                | 30. Name and address of person who completed cause of death (Item 23a)   |                                 |  |  |   |  |
|   |                |  | enn Street, Balt                | imore, MD 21201                          |  |   |  |
| S   | tate           | 31. Date filed (Month) Day, Year) A 2009 32. Registrar's Signature   | Pro                             |  |  |   |  |

DHMH 17 Rev 1/2001 OCME 2006

OCME

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Williams Kathleen Hastings 8:05 AM May 2008 11 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Berlin Nursing & Rehabilitation Ctr. Berlin Worcester If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 X 220-10-8370 88 Director 8/22/1919 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Wicomico Maryland Salisbury Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1514 Riverside Drive 21801 IISA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. and 2 should be filed within 72 hours after ealth and Mental Hygiene. 1 ∏Yes 2 🕱 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 XWidowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) operator telephone 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hiram Watson Emma Truitt ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12516 Nature Park Dr., Ocean City, MD 21842 19a. Informant's Name/Relationship (Type. Print) Sean A. Williams/grandson of Health 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition Pages 1 sting. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury Crematory 5/14/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Li HOTTOWAY Fuheral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Kuth Ha 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sero sclers **Physician** rdio Vasaula disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examine and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Soknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA P 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Delatural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No

After death. within 24 hours a To the Funeral I

State Registrar

Medical

2 Accident

3☐ Suicide

29a. Certifier

31. Date filed (/

4 ☐ Homicide

Nicholas

2008

6 ☐ Could not be

29c. License number

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Coastal Hyling Fawret Folial During

Year

who completed cause of death (Item 23a) (Type, Print)

and manner stated.

istrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie 2 1 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 0859 M 2008 Thelma Irene Hudson 0 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Regional SALISHU HICOMICE Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jan. 28, 1920 6. Sex Birthplace (State or Foreign Country) Social Security Number Days 1 ☐ M 2 🛱 F Yrs 88 213-22-8915 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b, County 1 XYes 2 No Worcester Snow Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21863 USA 108 East Martin Street 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: **Black** 3 XWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Domestic Engineer Elementary/Secondary (0-12) College (1-4or 5+) Laborer llth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ernest Jerome Johnson Jeanette Beatrice Hayward 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvester William Hudson/Son 828 Derbyshire Road - Daytona Beach, FL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Derivation 3 Removal from State May 13, 2008 Girdletree, MD \* 4 ☐ Donation 5 ☐ Other (Specify) Coolspring UMC Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Salisbury, Maryland Jolley Memorial Chapel, P.A. - 1213 Jersey Road 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):

**Physician** /Medical Examiner

1 - For State Registrar

PENINSULA

10a. State

MD

Director

Be Completed by Funeral

ဂ္ဂ

**Physician** 

/Medical

Examiner

**Funeral** 

Director

27 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Madical Examinar must be notified at

2 should be filed within 72 hours after death and Mental Hygiene.
Is marked other than "natural" or Homonal

Baltimore, Maryland 21215-0036

or Attending Physiclan: The law requires that the death certificate be executed the burial-transit

Box 68760,

Records, P.O.

Division of Vital

Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No

25. Was case referred to medical examiner?

29b. Signature and title of certifier

5 Pending investigation

6 Could not be

1 Tes 2 No

27. Manne of Death

1 Natural

2 Accident

3 🗌 Suicide

29a. Certifier

4 T Homicide

9 Unknown

IF FEMALE:

Certification: To Be Completed by Physician/Medical Medicai

after death.

within 24 hours a To tha Funeral C completely tilled To the Hospital

tilled in by the

State Registrar

Heyrer tension consequence of) Kheumats, d Due to (or as a consequence of):

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

23d. Date of delivery

24a. Was an autopsy performed 1 Yes 25

24b. Were autopsy findings available prior to completion of cause of death? 1 Tyes 2 No

Day

26. Place of Death (Check only one, Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred М 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 10041211 29d. Date signed (Month, Day, Year) 108

J. asla mis 30. Name and address of person who complied cause of death (Item 23a) (Type, Print)

lisbury, md. 21801 100 E. Carroll St. SA 31. Date filed (Mo 1 2 2008

|                            |  |                     | For<br>State<br>Registrar   | State of Marylar  |   | nt of Health and<br>te of Death   | Mental Hygiei                                      | ne<br>No. 2008                                  | 17428  |
|----------------------------|--|---------------------|---|---|---|---|--|---|--|
| 0                          | Physicia<br>/Medic<br>Examina  | ın<br>al            | 1. Decedent's Name (First, Middle, Last  Olanda  4a. Facility Name (If not institution, give  SALISBURY REHAB   | Rence   |   | y, Town, or Location of Deal<br>SALISBURY, M                            | 2. Date of Death<br>Month                          | Day Year  | 3. Time of Death 2.155 P M ICO                     |
|                            | Funeral<br>Director  |                     | 5. Social Security Number  5. Social Security Number  6. S  1  Usuat Residence of Decedent  | ex 7. Age (In yrs. 3  | A Yrs. If Und Months  | er 1 Year If Under 24 Hrs<br>s Days Hours Min                           |  | 9. Birthpla<br>Counti                           | ace (State or Foreign<br>ry)                       |
| 7                          | death with the Maryland<br>oms 23a or 28a-f show<br>if nast by ricelling at  |                     | 10a. State 10b. County  | om: co 5  | ty, Town or Location  | ^ <b>ų</b>  |  | 10  | od. Inside City Limits 1 (24) es 2 (1) No          |
| 7 /                        | h with th  | al Dire             | 10e. Street and Number 427 Jefferson  | झ   | 10f. 2  | 21804   | 10g.   | Citizen of What Count  U.S.A                    | ry?  |
| 7 A /<br>036               | s 1 and 2 should be filed within 72 hours after death with the Marylar f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event. It's Medical Exactinal most be rediffed at   | by Funeral Director | 11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced   | 12. Was Decedent Ever in U<br>Armed Forces?<br>1 □ Yes 2 ☑ No<br>tf Yes, Give<br>Year or Dates:   | If Yes, sp  | eedent of Hispanic Origin? (Specify Cuban, Mexican, Puer 28 No Specify: | Specify Yes or No-<br>to Rican, etc.)              | 14. Race - America<br>Black, White, e           |  |
| 15-0                       | in 72 ho<br>r netur  | Completed           | 15. Decedent's Ec<br>(Specify only highest gra  | ide completed)  | 16a. Decedent's Us<br>(Give kind of v<br>life. DQ NOT       | vork done during most of wo   | nrking 16b   | . Kind of Business/Indi                         | ıstry  |
| ) A                        | filed with<br>Hygiene.<br>other ther   | Com                 | Elementary/Secondary (0-12)   | College (1-4or 5+)  | 1   | rer   | 1 •  | ast Food  |  |
| V C                        | Mental H<br>Merked otl<br>arked otl  | To Be               | 17. Father's Name (First, Middle, Last) Robert Lee H  |   |   | CI.   | me (First, Middle, Maid<br>20eth +                 | orsey   |  |
| $A_{\Lambda}$ , Maryl      | 1 and 2 should<br>Health and Men<br>tem 27 is marke<br>other treumatic   |                     | 19a. Informant's Name/Relationship ( Elizabeth Faulco   | Type, Print) n Mother   | 427 Jef   | 1   | ural Route Number, Ci                              | ty or Town, State, Zip (                        |  |
| $\sqrt{OL}$                | Pages 1<br>nent of H<br>ant: if ite<br>ary or oth  |                     | 20a. Method of Disposition  1 ☑Burial 2 ☐Cremation 3 ☐  4 ☐Donation 5 ☐ Other (Specification of the content of | Removal from State  | Place of Disposition (Notemetery, crematory of Much Lucs le | n Cemetry 05-   |  | Location - City or Tov                          |  |
| Saltii C                   | permit. Pages<br>Department of<br>Important: If I<br>any Injury or one   |                     | 21. Signature of Funeral Service Licer  |   | 22. Name  | and Address of Facility   | Nony E. W  | ard Funeral                                     | Home   |
| 9                          | Physician<br>/Medical<br>Examiner  | _                   | 23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions   | a. Due to (or as a conset   | guence of):   | 7 3   | Correspiratory arrest,                             |   | Approximate<br>Interval Between<br>Onset and Death |
| 8760,                      | ysicia   | ilcal Examiner      | if any, leading to immediate cause. Enter Undertyling Cause (Disease or injury that initiated events resulting in death) Last   | c.  Due to (or as a consec  |   |   |  |   |  |
| P.O. Box 68                | Attending Physicien: The law requires thet the death certificat rideath.  •ctor: Atter this cartificate has been signed by the attanding phy by the funeral director, paga 2 should be detached for use as the   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  | 23c. If yes, outcome of pregn<br>1 ☐ Live birth 2 ☐ Fet<br>4 ☐ Pregnant at time of<br>9 ☐ Unknown | al death 3 □Ectopic   |   |  | 23d. Date of deliver<br>Month                   | ry<br>Day Year                                     |
|                            | w requires the<br>been signed to<br>should be det  | ۵                   | Part II. Other significant conditions of  | contributing to death but not re  | sulting in the underlying                                   | g cause given in Part I.  |  | co use contribute to the                        | e cause of death?<br>ably 4 Unknown                |
| Division of Vital Records, | icien: The law re<br>cartificate has be<br>rector, paga 2 sho  | Completed           |   |   |   |   | 24a. Was an autopsy performed                      | prior to com<br>death?                          | osy findings available apletion of cause of 2 No   |
| f Vit                      | nysician:<br>nis cartifica<br>I director, I  | To Be               | 25. Was case referred to medicat examiner? 1 Yes 2 1 No   | Hospital: 1 ☐ Inpatient 2 ☐   | ER/Outpatient 3□ (  | Othor   | eath (Check only one) Home 5 Residence             | e 6 Other (Specify                              | )  |
| o uo                       | ding Ph<br>lh.<br>After th<br>funeral  |                     | 27. Manner of Death  1 Haturat 5 Pending investigation  | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury<br>M                                 | 28c. Injury at Work? 1 ☐ Yes 2 ☐ No                                     | 28d. Describe how i                                | intury occurred                                 |  |
| Dívisi                     | i i i i  | Certification:      | 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined  | e One Blace of Injury At h  | nome, farm, street, factify)                                |   | 28f. Location (Stree<br>City or Town, S            | it and Number or Rural<br>state)                | Route Number,                                      |
|                            | To the Hospital or within 24 hours effa within 24 hours effact to the Funeral Direct completely filled in the form of the fore | Medical (           | 29a. Certifier 1 Certifying Pt<br>(Check only one) 2 Medical Exar   | nysician: To the best of my kn<br>miner: On the basis of examin<br>and manner stated.             | owledge, death occurre<br>ation and/or investigati          | ed at the time, date and place<br>on, in my opinion, death occ          | e, and due to the caus<br>surred at the time, date | e(s) and manner as sta<br>and place, and due to | ated.<br>the cause(s)                              |
|                            | To the within To the comple  | Me                  | 29b. Signature and title of certifier   | Allen   | 2   | 29c. License number   | 29d.   | Date signed (Month, D                           | Day, Year)   |
| <u> </u>                   | segu   |                     | 30. Name and address of person who WILLIAM ROBINS   | completed cause of death (Ite , M.D. 200 CIV  | m 23a) (Type, Print) /IC AVE - , S                          | SALISBURY, MD   | 21804  | C 36 30   |  |
|                            | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year) MAY 12 2  | 32. egistrar's Sign   | Stature Seeds   | ر<br>ر  |  |   |  |

**ORIGINAL** 

Ar

Registrar
DHMH 17 Rev 1/2001

MAY 29

#### 08-03488 Philip V. Ivantsov

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hydiene

|  | State of Maryland / Department of Health and Mental Hyglene  I-For State  Certificate of Death  Reg. No. 2008 1743   |
|--|--|
| Physician/   | 1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  DOE d. bro   |
| Medical Examiner   | Philip Valerevich Ivantsov May 7, 2008 USS INS  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  |
|  | 4954 Wyconda Place Rockville Montgomery  |
| Funeral  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9: Birthplace (State or Foreign   |
| Director   | 578-23-6192   1x M 2 F   23 Yrs.   Months Days Hours   Min.   01/15/1985   Country)Russia  |
| any  | 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits   |
| Aaryland<br>28a-f show<br>1 at once.<br>ector  | Maryland Montgomery Rockville  |
| tih the Maryland<br>23a or 28a-f sho<br>notified at once.<br>al Director   | 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?   |
| ith the 23a o  | 12403 Braxfield Court #11 20852 United States  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-   |
| or items 23<br>must be no  | 1 X Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.  |
| ral", o  | 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White  |
| "natu<br>Exam  | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |
| 5-0036 ed within 72 hours lygiene "natu the Medical Exan   | 12 Producer / Poet Music   |
| 15-0<br>filed w<br>Hygie<br>d othe   | 17. Father's Name (First, Middle, Last)  Valery Tyantsoy  Anna Arkadyevna Shevchenico  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director | Valery Ivantsov Anna Arkadyevna Snevchenico  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  |
| MD<br>12 sho<br>th and<br>1.27 is<br>tumati  | Valery Ivantsov / Father 12403 Braxfield Ct. #11, Rockville, MD 20852  |
| ore, so I and of Heal  | 20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  Date  20c. Location - City or Town, State  |
| time: Page trant:  | Parklawn Mem. Park 5/14/2008 Rockville, MD   |
| Ball<br>permii<br>Depar<br>Impo  | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852  |
| Physician  | 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and   |
| /Medical<br>** Fxaminer  | Immediat- Cause (Final disease a. Multiple Injuries  |
|  | h  |
| iner   | Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlyin, Cause  |
|  | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):   |
| 60, rate be executed physician and the burial - transit Medical Exa  | d. UNPENDED AMENDED  |
| 50,<br>te be e:<br>sysician<br>burial  | UNPENDED AMENDED  IF FEMALE: 23d. If yes, outcome of pregnancy 23d. Date of delivery   |
| 687(ertifica<br>ertifica<br>ding pt<br>e as the  | 23b. Was decedent pregnant in the past 12 months?   1 Live birth 2 Fetal death 3 Ectopic pregnancy   Month Day Year  |
| ). Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit Physician/Medical Examiner   | 1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown   |
| Division of Vital Records, P.O. B spital or Attending Physician: The law requires that the d tours after death.  reral Director: After this certificate has been signed by the filled in by the funeral director, page 2 should be detached Certification: To Be Completed by Phy  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 V No 3 Probably 4 Unknown  |
| S, P.( puires tha a signed ald be det  | 24a. Was an 24b. Were autopsy findings available   |
| Records, The law requires ficate has been sig. page 2 should be  | autopsy prior to completion of cause of performed? death?  |
| Reci: The fiftcate r. page   | 25. Was case referred to medical 26.Place of Death (Check only one)  |
| Vital ysician his certi director   | examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 ✓ Other: Scene  |
| n of ing Ph  | 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject struck by train   |
| ivision<br>for Attend<br>after death.<br>Director:<br>d in by the f  | 1 Natural 5 Pending Investigation 2 Accident Investigation 2 Replace of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City  |
| Division o spiral or Attending from shours after death. Increal Director: After filled in by the frine Certification:  | 3 Suicide 6 Could not be determined Specify) Other (train tracks)  Suicide 4 Homicide Specify) Other (train tracks)  Solicide 4 Homicide Specify) Other (train tracks)   |
| 8 - 2 - 1  | 29a. Certifier 1 Certifying Phy ian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |
| To the Howithin 24 h To the Fur completely   | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  |
| <u></u> 2 ≥  | O.C.M.E. May 8, 2008   |
|  | 30. Name and add us of person who completed cause of death (Item 23a)  |
| OCME   | Mary G. Rypple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201  |
| State<br>Registrar   | CONTROL TO THE THE THE PROPERTY AND A PART |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 17 perfh 9881 7-28-08 VL State of Maryland? Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2008 **Physician** 2042 MAY 8 BERNARD WILSON JOHNSON /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMERY General Hospital Olney Montgomery Date of Birth (Month, Day, Year) Dec. 18,1942 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 XM 2 ☐ F 216-40-7210 65 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 28a-f show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 No Silver Spring Director MD Montgomery 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 20906 U.S.A. 3520 Pear Tree Court by Funeral death 14. Race · American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any filury or other traumatic event, Its Modical Evantual once. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify:Black 3 Widowed 4X Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United Disposal Laborer 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frances Matthews Hopson Johnson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12516 Great Park Cir, Germantown, MD (Daughter) Ashleigh M.Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burjat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5/14/08 Silver Spring,MD Gate of Heaven Cem 21. Signature of Funeral Service Linear ed 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** woline min /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (o Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ NO 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Oreumanis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Thomicide within 24 hours aft

To the Funeral Di

completely filled in Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the Med Smel 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2 050410 10 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr

State Registrar Olney

|             |  | ·             | 1 - For State Registrar  | e of Maryland  |                    | artment o                             |                           |                       |                            | R                              | eg. No <b>2</b>             | 08                                   | 17432  |
|-------------|--|---------------|--|--|--------------------|---------------------------------------|---------------------------|-----------------------|----------------------------|--------------------------------|-----------------------------|--------------------------------------|--|
|             | Physici  | an            | Decedent's Name (First, Middle, Last)  |  |                    |                                       |                           |                       | 2                          | 2. Date of Dea<br>Month        | Day                         | Year                                 | 3. Time of Death                                 |
|             | /Medic   | cal           | CELIA A. KRAMER  4a. Facility Name (If not institution, give street and  | f number)  |                    | 4b. City, To                          | own. or Loc               | cation of             | f Death                    | May                            |                             | 2008<br>by of Death                  | 4:30 P M   |
| 2           | Examin   | ner           | 7608 River Falls Driv  |  |                    | Poto                                  |                           |                       |                            |                                |                             | gomer                                | у  |
|             | Funeral  |               | 5. Social Security Number 6. Sex   | 7. Age (In yrs. last   | birthday)          | If Under 1 Months D                   |                           | Under 2               | 24 Hrs. 8                  | Date of Birth                  | . Year)                     | Cour                                 | place (State or Foreign                          |
|             | Director   |               | 578-50-3514 1 M 2X   | <sup>F</sup> 69  | Yrs.               | MOTATS                                | Days                      | louis                 |                            | (Month, Day<br>July 30         | , 1938                      | Wash                                 | ington, DC                                       |
|             | land   |               | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, To  | own or Lo          | ocation                               |                           |                       |                            |                                |                             | 1                                    | Od. Inside City Limits                           |
| May V       | Mary<br>I sh   | ţo            | Maryland Montgomery  | Pot  | omac               |                                       |                           |                       |                            |                                |                             |                                      | 1 ☐ Yes 21 No                                    |
|             | th the   | Director      | 10e. Street and Number   |  |                    | 10f. Zip Co                           |                           |                       |                            |                                | log. Citizen of             | What Cour                            | ntry?  |
|             | s filed within 72 hours after death with the Maryland<br>Hygiene.<br>other than "natural", or Itams 23a or 28a-f show<br>vant, Ita Mazical Examinar must be natified at  | a             | 7608 River Falls Driv  |  |                    | 208                                   |                           |                       |                            |                                | U.S.A.                      |                                      |  |
|             | er dez   | Funeral       | 11. Marital Status 12. Was Arme  | Decedent Ever in U.S.<br>d Forces?<br>'es 2 No   | 13.                | Was Deceder<br>If Yes, specify        | nt of Hispa<br>y Cuban, N | anic Orig<br>Mexican, | jin? (Speci<br>, Puerto Ri | fy Yes or No-<br>can, etc.)    |                             | ice - Americ<br>ack, White,          |  |
| 50          | II, or   | by F          | If Yes   | es 201 No<br>, Give<br>or Dates:   |                    | 1□Yes 2€                              | No S                      | Specify:              |                            |                                | Speci                       | ify:                                 | White  |
| o-0030      | 2 hou<br>latura<br>ical E  | ted           | 15. Decedent's Education   |  | 6a. Dece           | dent's Usual (                        | Occupation                | n<br>n                | of working                 |                                | 16b. Kind of E              | Business/In                          | dustry   |
| <u>~</u>    | thin 7   | Completed     | (Specify only highest grade completed in the complete state of the | ge (1-4or 5+)  |                    | kind of work of NOT use               |                           | ng most               | OI WOIKING                 | ′                              |                             |                                      |  |
| 7           | led will her the the the the the the the the the the   |               | 17. Falbada Nama (First Middle (1994)  | 5+   | Phy                | sician                                |                           | Mathar                | do Namo (                  | First Middle                   | Medi.<br>Maiden Suma        |                                      |  |
| yland       | d be fi  | Be            | 17. Father's Name (First, Middle, Last)  Charles Le Roy Sher   | man  |                    |                                       |                           |                       |                            | Davis                          |                             | uno,                                 |  |
| 2           | should<br>nd Me<br>mark<br>matic   | 2             | 19a. Informant's Name/Relationship (Type, Print  |  | 9b. Maili          | ng Address (S                         |                           |                       |                            |                                | r, City or Towr             | n, State, Zip                        | Code)  |
| Z           | alth ar  |               | Mr. Robert Kramer -  | Husband  | 7608               | River                                 | Fall                      | ls D                  | rive,                      | Potom                          | ac, MD                      | 2085                                 | 4  |
| Baitimore,  | es 1 a<br>of He<br>of He<br>rothe  |               | 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal f  |  |                    | osition (Name<br>matory or othe       |                           |                       | Da                         |                                | 20c. Location               | -                                    |  |
|             | Pag<br>ment<br>tant: I<br>jury o   | 1             | `4 ☐ Donation 5 ☐ Other (Specify)  | Fort   |                    |                                       |                           | -                     |                            | /2008                          | Brentw                      | ood,                                 | MD   |
| מ           | permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic evant, Item once.   |               | 21. Signature of Funeral Service Licensee  |  |                    | 2. Name and<br>remation               |                           |                       | 2 THE                      | le Tri                         | butes<br>MD 208             | Funer<br>1ke,<br>52                  | al &   |
|             |  |               | 23a. Part1. Enter the diseas and complications to shock, or hear failure. List only one cause  | nat caused the death. I  |                    |                                       |                           |                       |                            |                                |                             | S 1025 25                            | Approximate<br>Interval Between                  |
| 1           | Physician  |               | Immediate Caula Final disease or condition   | 4  | ung                | (                                     | 0.700                     | -                     |                            |                                |                             | 3                                    | Onset and Death                                  |
|             | /Medical<br>Examiner   |               | resulting in death)  | e to (or as a consequen  | ce of):            |                                       |                           |                       |                            |                                |                             |                                      |  |
|             |  | آة.           | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  | e to (or as a consequen-   | ce of):            |                                       |                           |                       |                            |                                |                             |                                      |  |
|             | d<br>d<br>ansit  | Examiner      | that initiated events C.   |  |                    |                                       |                           |                       |                            |                                |                             |                                      |  |
| Ž,          | rate be executed<br>hysician and<br>the burial-transit   |               |  | e to (or as a consequen  | ce of);            |                                       |                           |                       |                            |                                |                             |                                      |  |
| 0/8<br>8/90 | certificate be executed<br>iding physician and<br>ise as the burial-transit  | dlcal         | d  |  |                    |                                       |                           |                       |                            |                                |                             |                                      |  |
| ٥<br>×      | leath certifica<br>attending ph<br>I for use as th   | Physician/Med | IF FEMALE: 23c. If yes   | , outcome of pregnancy   |                    |                                       |                           |                       |                            |                                | 23d. D                      | ate of deliv                         | erv  |
| X<br>Q      | atter<br>for u   | ician         | in the past 12 months?   | ive birth 2 🗍 Fetal de<br>regnant at time of death   | ath 3[             | ∃Ectopic preg<br>∃ Other <i>(spec</i> |                           |                       |                            |                                |                             | fonth                                | Day Year   |
|             | w requires that the debeen signed by the should be detached  | hysi          | 9 □ Unknown 9□ U   | Inknown  |                    |                                       |                           |                       |                            |                                | J.                          |                                      |  |
| ,           | requires that the<br>een signed by th<br>hould be detache  | by P          | Part II. Other significent conditions contributing   | to death but not resulting   | ig in the u        | nderlying cau                         | ise given ir              | in Part I.            |                            |                                |                             |                                      | he cause of death?                               |
| cords       | Ben si   | ted           |  |  |                    |                                       |                           |                       |                            | 1 <u>A</u> Y                   | es 2□No                     | 3 ∐ Prot                             | pably 4 □Unknown                                 |
| ပ္          | 2 5 8  | Completed     |  |  |                    |                                       |                           |                       |                            | 24a. Was a<br>autop:<br>perfor | sv                          | . Were auto<br>prior to co<br>death? | opsy findings available<br>impletion of cause of |
|             | Page at Page   |               |  |  |                    |                                       |                           |                       |                            | 1 Yes                          | 2 🔼 No                      | 1 ☐ Yes                              | 2 No   |
| <b>=</b>    |  | o Be          | 25. Was case referred to medical examiner?  1 ☐ Yes 2☒ No  Hospital:   | 1 ☐ Inpatient 2 ☐ ER   | /Outpatier         | nt 3 DOA                              |                           |                       |                            | Check only or                  | ne)<br>ence 6 □O            | ther (Specia                         | f <sub>v</sub> )                                 |
|             | g Phys<br>er this<br>eral di   | n: To         | 27. Manner of Death 28a. I   | the second secon | b. Time o          |                                       | c. Injury at<br>Work?     |                       |                            |                                | ow injury occu              |                                      | 97   |
| VISION      | Attanding I<br>r death.<br>actor: After<br>by the funer  | atlo          | 2 Accident investigation   | wionini, Day Tear)   | Піцагу             | М                                     |                           | s 2□N                 | No                         |                                |                             |                                      |  |
|             |  | ertification: | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined 28e.   | lace of Injury - At home uilding, etc. (Specify)   | , farm, sti        | reet, factory, o                      | office                    |                       | 28                         | of. Location (S<br>City or Tow | itreet and Nun<br>n, State) | nber or Rur                          | al Route Number,                                 |
|             | spital   | O             | 29a. Certifier 1 X Certifying Physicien: T   |  |                    |                                       |                           |                       |                            |                                |                             |                                      |  |
|             | To tha Hospital or within 24 hours afte To tha Funaral Dir completely filled in  | edical        | (Check only 2 Medical Examiner: On the   |  |                    |                                       |                           |                       |                            |                                |                             |                                      |  |
|             | To the company of the | Ž             | 29b. Signature and title of certifier  |  |                    | 29c. l                                | License nu                | umber                 |                            | 2                              | 29d. Date sign              |                                      |  |
| ,           | 16   |               | · por  |  |                    |                                       | 10105                     | 5247                  | 7                          |                                | ر                           | /-3/                                 | 108  |
|             |  |               | 30. Name and address of person who completed Gregory Orloff 850  | cause of death (Item 23) 3 Arlington   | a) (Type.<br>n B1: | Print)<br>vd, Fa:                     | irfax                     | v, VA                 | A 2203                     | 31                             |                             |                                      |  |
|             | Sta  | ate_          |  |  |                    |                                       |                           |                       |                            |                                |                             | <del></del> -                        |  |
|             | Registi  |               | MAY 1 4 2008   | 32. Regetrar's Signature   | O. 1               | goest                                 | 1                         |                       |                            |                                |                             |                                      |  |

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician May 20, 2008 10:00 P.M Cora Lee Kane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent & Rehab. Center Anne Arundel Crofton Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🗓 F Director 9/28/1916 579-16**-**4191 Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10d. Inside City Limits if of Health and Mental Hygiene.
If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Its Modical Evaning must be notified at 10c. City. Town or Location 1∐Yes 2∭XNo Directo Maryland Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2800 Nicodemus Road 21157 U. S. A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ∐Yes 2 DxNo Specify. Specify: White <u>چ</u> 3 Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Day Care Worker Child Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ George Fewell Cora Lee Dudley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2800 Nicodemus Road, Westminster, MD Elaine M. Wood-daughter altimore, 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ō Department of Important: If any injury or once. Cedar Grove Cemetery May 24, 2008Bealeton, Virginia 21. Signaty of Funeral Service Licensee 22. Name and Address of Facility Moser Funeral Home, Inc. 233 Broadview Ave., Warrenton, VA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Athenoschenotic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Demen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sician and burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ cate has been si 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 □Yes 1 □ Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this 27. Wriner of De 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending Natural 2 ccident Injury within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 No filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) of certific 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane, Ste. 222, Bowie, MD 20715 Rakesh Arora, MD, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

200

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Treva Auman Mattia May 10, 2008 10:15 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1115 Dryden Street Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 XF Sept. 6, Director 238-30-1243 84 1923 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits show r 28a-f show notified at 1 ☐Yes 2 ☐No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code giene. r than "natural", or items 23a or the Medical Examiner must be r 20901 1115 Dryden Street USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 Ho Specify: Completed by Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (3-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiene Important: If item 27 is marked other the any lijury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gurney Lester Auman Elah Davis မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4707 Howard Avenue, Beltsville, MD 20705 Sharon Gardiner/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State May 1 Burial 2 □ Cremation 3 □ Removal from State Columbia Primitive Baptist 2008 4 ☐ Donation 5 ☐ Other (Specify) Burtonsville, Maryland Francis Jess of Facility Francis Jess of Facility Francis Jess of Facility 21. Signal to of F) neral Service Lives see whord & Hales 500 University Blvd, W. Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Clostridium Difficile Colitis 2 months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the conditions of the conditions of the cause of the Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-trail resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physician Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Atrial Fibrillation, Diabetes Mellitus (Type II) 1 Yes 2√MNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate 1∐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 1 X Natural after death. 1 Tyes 2 No

5 Pending investigation 2 Accident 3 Suicide

29b. Signature and title of certifier

29a. Certifier

(Check only one)

6 ☐ Could not be 4 Homicide

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

1 Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number DOO 61445

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mary Ellen Ritchie, MD 31. Date filed (Month, Day)

12201 Plum Orchard Drive, Silver Spring, MD 20904

State Registrar

Medical

32. P gistrar's Signature 2008 4



To the Hospital o within 24 hours aft To the Funeral Di

Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: filem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Eugene Mills Baltimore, Maryland 21215-0036 Physician /Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Medical Certification: To Be Completed by Physician/Medical Eva Division or Vital Records, P.O. Box 68760,

Physician /Medica Examine

**Funeral** 

|                                  |  | Plea                               |   |                                       |                       |                        | i <b>delible Ink</b><br>artment of I     |                              |                              |                                | _                | ibie.                        |  |
|----------------------------------|--|------------------------------------|---|---------------------------------------|-----------------------|------------------------|--|------------------------------|------------------------------|--------------------------------|------------------|------------------------------|--|
|                                  | 1 - For<br>State<br>Registrar                                      |                                    |   | ate of N                              | naryiari              |                        | rtificate of                             |                              |                              | Re                             | g. No. 2         | 108                          | 17135  |
| an<br>al                         | Decedent's Name  EUGENE  | e (First, Midd                     |   | LLS                                   |                       |                        |  |                              | _                            | Date of Death<br>Month         | Day 3, 20        | Year<br>OS                   | 3. Time of Death                                   |
| er                               | 4a. Facility Name (I   |                                    |   |                                       | r)                    | 0.1                    | 4b. City, Town, o                        | or Location of               | f Death                      |                                | 4c. Count        | y of Death                   |  |
|                                  | Salishu  |                                    |   |                                       | sing                  |                        |  | SDU (                        |                              | Date of Birth                  | LW               | Com                          | lace (State or Foreign                             |
|                                  | 5. Social Security N 220-28-0 Usual Residence of                   | 545                                | 6. Sex<br>1 🛂 M                                 |                                       | Age (III yas. I       | 74 Yrs.                | Months Days                              | Hours                        | Min.                         | (Month, Day,<br>/18/193        | Year)            | Mary]                        | try)   |
|                                  | 10a. State   | 10b. Count                         | у   |                                       | 10c. City             | y, Town or Lo          | ocation                                  |                              |                              |                                |                  | 11                           | 0d. Inside City Limits                             |
| Be Completed by Funeral Director | MD   | Worce                              | ester   |                                       | Poo                   | comoke                 | City                                     |                              |                              |                                |                  |                              | 1 X Yes 2 □ No                                     |
| Dìre                             | 10e. Street and Nu   | mber                               | ·   |                                       |                       |                        | 10f. Zip Code                            |                              |                              | 10                             | g. Citizen of    | What Coun                    | try?   |
| ral                              | 934 Clar   | ke Ave                             |   |                                       | .5                    |                        | 21851                                    |                              |                              |                                | 14 Do            | USA                          | no lodico  |
| -une                             | 11. Marital Status<br>1 □ Never Marr                               | iod 2□Ma                           | , A   | Vas Deceder<br>Armed Force:<br>☑Yes 2 | s?                    | S.   13.               | Was Decedent of I<br>If Yes, specify Cub | Hispanic Orig<br>an, Mexican | gin? (Specif<br>, Puerto Ric | y Yes or No-<br>can, etc.)     |                  | ce - America<br>ck, White, o |  |
| by F                             | 3 X Widowed  |                                    | 1 1   | Yes, Give<br>ear or Dates             | _                     |                        | 1 ☐ Yes 2 🔀 No                           | Specify:                     |                              |                                | Speci            | <sup>fy:</sup> whit          | æ  |
| ted                              | /Snor  | 15. Decede                         | ent's Education<br>est grade con                | n<br>mplatad)                         |                       | 16a. Dece              | edent's Usual Occu                       | pation                       | of working                   | 1                              | 6b. Kind of E    |                              |  |
| nple                             | Elementary/Seco  |                                    |   | College (1-4a                         | r 5+)                 | life.                  | DO NOT use retire                        | rd)                          | or working                   |                                |                  |                              |  |
| Co                               | unk  | (First \$41441                     | - (+)   |                                       |                       | Mana                   | gement                                   | 10 Mothor                    | ra Nama /F                   |                                | Consti           |                              | on   |
|                                  | 17. Father's Name  | `                                  |   | -                                     |                       |                        |  |                              | n How                        | First, Middle, M               | aiden Surna      | me)                          |  |
| 卢                                | Robert L   |                                    | <u>'</u>  |                                       |                       | 19h Maili              | ng Address (Street                       | 1                            |                              |                                | City or Town     | State Zin                    | Code)  |
| 16                               | Richard  |                                    | 1 ( ),  |                                       | er)                   | 1                      | Jones Ro                                 |                              |                              |                                | •                |                              | 0000)  |
| 19                               | 20a. Method of Disj  | position                           |   |                                       | 20b. P                | lace of Disp           | osition (Name of<br>ematory or other pla | i                            | Date                         |                                | Oc. Location     |                              | wn, State  |
|                                  | 1X Burial 2<br>4 ☐ Donation  |                                    |   | val from Sta                          | e   .                 |                        | ist Cemeter                              | 1 1 -                        | /16/2                        | 008                            | Pocomo           | ke Cit                       | cv. MD   |
| ΙÝ                               | 21. Signature of Fu  | uneral Servic                      | e Licensee                                      |                                       | 19/45                 |                        | 2. Name and Addr<br>Olloway I            |                              |                              |                                |                  |                              |  |
|                                  | Mu   | hal                                | AD  | ean                                   |                       | 17                     | 03 Linder                                | Ave.                         | , Poc                        | omoke C                        | ity, N           | 4D 218                       | 851  |
|                                  | 23a. Part1. Enter t<br>shock, or hea                               | the disease, o<br>art failure. Lis | or complications or complications only one care | ons that crus                         | ed the death<br>line. | n. Do not en           | ter the mode of dy                       | ng, such as                  | cardiac or r                 | espiratory arre                | st,              |                              | Approximate<br>Interval Between<br>Onset and Death |
| H                                | Immediate Cause (  |                                    | -0  | Lan                                   |                       | Care                   | cen                                      |                              |                              |                                |                  |                              | 4 lat-   |
|                                  | resulting in death)  |                                    |   | Due to (or a                          | a consequ             | uence of):             | 0  |                              |                              |                                |                  | A                            | 7.   |
| 7                                | Sequentially list co<br>if any, leading to in<br>cause. Enter Unde | nditions,                          | b. <u>C</u>                                     | Due to (or a                          | as a consequ          | uence of):             | stone                                    | levi                         | - 6                          | alm                            | soy              | Nes                          | core yu  |
| Examiner                         | Cause (Disease of  | murv                               | <   |                                       |                       |                        |  |                              |                              |                                | 1                |                              | 2  |
| Еха                              | that initiated events<br>resulting in death) I                     | Last                               | с   | Due to (or a                          | as a consequ          | uence of):             |  |                              |                              |                                |                  |                              |  |
| cal                              |  |                                    | d   |                                       |                       |                        |  |                              |                              |                                |                  |                              |  |
| Medi                             | IF FEMALE:   |                                    |   |                                       |                       |                        |  |                              |                              |                                |                  |                              |  |
| lan/                             | 23b. Was deceden   |                                    |   | f yes, outcon<br>I ∐Live birth        | 2 🗆 Feta              | death 3                | ⊒Ectopic pregnanc                        | ;y                           |                              |                                |                  | ate of delive                | ry<br>Day Year                                     |
| /sici                            | 1 ☐ Yes 2 ☐<br>9 ☐ Unknown   | □No                                |   | 4□Pregnant<br>9□Unknown               |                       | eath 5[                | Other (specify)                          |                              |                              |                                |                  |                              | Day Tour   |
| Ph                               | Part II. Other signi   |                                    | tions contribu                                  | iting to death                        | but not resu          | ulting in the u        | underlying cause gi                      | ven in Part I.               |                              | 23e. Did tob                   | acco use cor     | ntribute to th               | ne cause of death?                                 |
| Completed by Physician/Medic     |  |                                    |   |                                       |                       |                        |  |                              |                              | 1 <b>△</b> ¥€                  | s 2□No           | 3 ☐ Prob                     | ably 4 □Unknown                                    |
| lete                             |  |                                    |   |                                       |                       |                        |  |                              |                              | 24a. Was an                    | 24b              | Were auto                    | psy findings available                             |
| ошр                              |  |                                    |   |                                       |                       |                        |  |                              |                              | autopsy<br>perform<br>1∐ Yes 2 | /<br>ned?<br>PNo | death?                       | inpletion of cause of<br>2 ☐ No                    |
| Be C                             | 25. Was case refer   | rred to medic                      | al  |                                       |                       |                        |  | 26. Place                    | of Death (0                  | Check only one                 |                  | ППтез                        | 2 140  |
| 일                                | examiner?<br>1 ☐ Yes 2 ☐   | NO                                 | Hosp  | ital:<br>1 ☐ Inpa                     | itient 2 🗆            | ER/Outpatie            | m 3 DOA                                  |                              | rsing Home                   | 5 Reside                       | nce 6 □Ot        | her (Specif                  | /)   |
| on:                              | 27. Manner of Deat   | th<br>5 ∏Pend                      |   | Ba. Date of It<br>(Month, I           | njury<br>Day Year)    | 28b. Time of<br>Injury | Wo                                       |                              |                              | d. Describe ho                 | w injury occu    | rred                         |  |
| cati                             | 2 ☐ Accident<br>3 ☐ Sulcide  | 6 ☐ Could                          |   | Po Place of                           | niun, At ha           | omo farm et            | M 1 Creet, factory, office               | ]Yes 2□N<br>-                |                              | Location (Ctr                  | not and Muse     | hos os Dura                  | I Doub Number                                      |
| ertif                            | 4 ☐ Homicide   | deter                              | mined 2   | building,                             | etc. (Specify         | y)                     | reet, ractory, office                    |                              | 2.01                         | City or Town                   | State)           | bei oi nuia                  | l Route Number,                                    |
| Medical Certification:           | 29a, Certifier   |                                    |   |                                       |                       |                        | th occurred at the t                     |                              |                              |                                |                  |                              |  |
| edic                             | (Check only one)   | 2 Medica                           |   | On the basis<br>and manner            |                       | tion and/or ii         | nvestigation, in my                      | opinion, dea                 | th occurred                  | at the time, da                | ate and place    | , and due to                 | the cause(s)                                       |
| ž                                | 29b. Signature and   | I title of certifi                 | iof in  |                                       |                       |                        | 29c. Licen                               | se number                    |                              | 29                             | d. Date sign     | ed (Month,                   | Day, Year)   |
|                                  | 111  | 111                                | 11/   | -6-                                   |                       |                        | 100                                      | 13                           | 4                            | P                              | 8/1              | 100                          | £  |
|                                  | 30. Name and add   |                                    | Robi  |                                       | ~                     |                        | Print) O CIVIC                           | AUP                          | (51                          | isburu                         | · MT             | 21                           | 804  |
| te                               | 31. Date filed (Mon  | nth, Day, Yea                      | r)  |                                       | strar's Signa         |                        | - ONIC                                   | 11001                        | w                            |                                | 11114            | - XI                         | 00 1   |
| ar                               | M  | IAY 15                             | 5 2008  | Buch                                  | we s                  | K A                    | morte                                    |                              |                              |                                |                  |                              |  |

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State Registra

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|                     |  |                   | For<br>State<br>Registrar   | State o                                 | f Marylan                           |                       | artment of I   |                           |                            | lental H                           | ygiene<br>Reg. No        | 2008                       | 3 174   | 36      |
|---------------------|--|-------------------|---|---|-------------------------------------|-----------------------|--|---------------------------|----------------------------|------------------------------------|--------------------------|----------------------------|---|---------|
|                     | Di   |                   | 1. Decedent's Name (First, Middle,  | Last)                                   |                                     |                       |  |                           |                            | 2. Date of D                       |                          |                            | 3. Time of De   | ath     |
|                     | Physici<br>/Medi   |                   | William Henr  | y Mason                                 | l .                                 |                       |  |                           |                            | 05                                 | 11                       | 2008                       |   | PM      |
|                     | Examir   | ner               | 4a. Facility Name (If not institution, PENINSULA REGIO                              | -                                       |                                     | ਧੁਤਾ                  | 4b. City, Town, o  |                           | of Death                   |                                    | 40                       | . County of De WICOM       |   |         |
|                     | Funeral  |                   | 5. Social Security Number   | 6. Sex                                  | 7. Age (In yrs.                     |                       | If Under 1 Year  | If Unde                   | er 24 Hrs.                 | 8. Date of B                       | irth (                   | -                          | rthplace (State or F                                      | oreigr  |
|                     | Director   |                   | 209-40-9458   | 1 <b>X</b> M 2 □ F                      | 57                                  | Yrs.                  | Months Days  | Hours                     | Min.                       | 8. Date of B<br>(Month, L<br>4/1/1 | 951                      | T                          | exas  |         |
|                     | and  |                   | Usual Residence of Decedent  10a. State 10b. County                                 |   | 10c, Cit                            | y, Town or L          | ocation  |                           |                            |                                    |                          |                            | 10d. Inside City L  | ∟imits  |
|                     | Maryl<br>F sho   | to                | Maryland Wico   | mico                                    |                                     | Salisb                |  |                           |                            |                                    |                          |                            | 1 ☐ <b>X</b> Yes 2[                                       | □No     |
|                     | or 28a   | Director          | 10e. Street and Number  |   |                                     | Jarron                | 10f. Zip Code  |                           |                            |                                    | 10g. Ci                  | tizen of What C            | ountry?   |         |
|                     | hours after death with the Maryland<br>tural", or items 23a or 28a-f show<br>at Examiner nast be notified at   | ral               | 228 Canal Park  |   |                                     |                       | 2180   |                           |                            |                                    |                          | USA                        |   |         |
|                     | items<br>items   | Funeral           | <ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☐ Marrie</li></ul>           | Armed Fo                                | edent Ever in U.<br>rces?           | S.   13.              | Was Decedent of I<br>If Yes, specify Cub                       | Hispanic O<br>pan, Mexica | origin? (Spe<br>an, Puerto | ecify Yes or N<br>Rican, etc.)     | lo-                      | 14. Race - An<br>Black, Wh |   |         |
| 036                 | urs af<br>al", or  |                   | 3 ☐ Widowed 4 🕱 Divorced  | If Yes, Gi<br>Year or D                 | <sup>2</sup> □No<br>ve<br>ates:Navy |                       | 1 □Yes 2 No  | Specify                   | y:                         |                                    |                          | Specify:                   | white   |         |
| 5-0                 | 72 ho  | Completed by      | 15. Decedent's<br>(Specify only highest   | s Education<br>t grade completed)       |                                     | 16a. Dece             | edent's Usual Occu<br>e kind of work done<br>DO NOT use retire | pation<br>during mo       | ost of worki               | ng                                 | 16b. K                   | (ind of Busines            | s/Industry  |         |
| 121                 | within<br>ene.<br><b>than</b>  | I I               | Elementary/Secondary (0-12)   | College (1                              | -4or 5+)                            |                       | DO NOT use retire<br>ntenance                                  |                           |                            |                                    | ma                       | aintena                    | nce   |         |
| d 2                 | filed v<br>I Hygid<br><b>other</b><br>ent.   | Be Co             | 17. Father's Name (First, Middle, L   | .ast)                                   |                                     |                       |  | 18. Moth                  | her's Name                 | (First, Middl                      | le, Maider               |                            |   |         |
| /lan                | uld be<br>Mental<br>rked<br>tic ev   | To B              | Peter Mason   |   |                                     |                       |  | Ma                        | ary A                      | llemor                             | е                        |                            |   |         |
| Maryland 21215-0036 | permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; any injury or other traumatic event. In Medical Exagons.   | ľ                 | 19a. Informant's Name/Relationsh  |   |                                     | 1                     | ing Address (Stree   |                           |                            |                                    |                          |                            |   |         |
| e<br>S              | f and<br>Health<br>Sm 27<br>ther to  |                   | Mary Mason/moth 20a. Method of Disposition  | er                                      | 20h F                               | 1                     | l N. U.S.  |                           |                            | OO, Ti                             |                          | ocation - City o           |   |         |
| Baltimore,          | ages<br>ent of l<br>t: If ite  |                   | 1 ☐ Burial 2 ☐ Cremation  |   | State                               |                       | osition (Name of matory or other pla                           | i                         |                            |                                    |                          | -                          |   |         |
| alt:                | mit. Partme  |                   | 4 ☐ Donation 5 ☐ Other (Sp<br>21. Signature of Funeral Service ☐                    | 1                                       | Sal                                 | lisbur                | y Cremato<br>2. Name and Addre                                 | ess of Faci               | 5/13                       | /08                                | 5                        | alisbur                    | y, ND   | 10      |
| ñ                   | Imp<br>any<br>any  |                   | > Kett K &  | lergery                                 | (FJP)                               |                       | 501 Snow   | / Fune<br>/ Hil           | erai<br>1 Rd.              | , Sali                             | sbury                    | y, MD 2                    | Associat<br>1804  | TOI     |
|                     |  |                   | 23a. Part 1. Enter the disease, or o<br>shock, or heart failure. List o             | complications that conly one cause on e | aused the deatl<br>ach line.        |                       |  |                           |                            |                                    |                          |                            | Approximate<br>Interval Between                           | en      |
|                     | Physician  |                   | Immediate Cause (Final disease or condition resulting in death)                     | _a €                                    | Sopha                               | real                  | Cance  | -                         |                            |                                    |                          |                            | Onset and Dea   |         |
|                     | /Medical Examiner  |                   | rooming in dodn'y   | Due to                                  | or as a conseq                      | uence of):            |  |                           |                            |                                    |                          |                            |   |         |
|                     |  | Jer               | Sequentially list conditions, if any, leading to immediate Cause (Disease or injury | b. — Due to                             | or as a conseq                      | uence of):            |  |                           |                            |                                    |                          |                            |   |         |
|                     | scutec<br>ind<br>transit   | Examiner          | that initiated events   | c                                       |                                     |                       |  |                           |                            |                                    |                          |                            |   |         |
| 8760,               | certificate be executed iding physician and se as the burial-transit   | E<br>E            | resulting in death) Last  | Due to                                  | or as a consequ                     | uence of):            |  |                           |                            |                                    |                          |                            |   |         |
| \$ 589<br>587       | ficate<br>g phys   | edical            |   | d                                       |                                     |                       |  |                           |                            |                                    |                          |                            |   |         |
| 7.8%<br>Box 6       | h certi<br>ending<br>use a   | Physician/Me      | IF FEMALE:<br>23b. Was decedent pregnant  |   | come of pregna                      |                       |  |                           |                            |                                    | ļ                        | 23d. Date of d             | elivery   |         |
| ` =                 | e death<br>he atter<br>ed for u  | sicia             | in the past 12 months?<br>1 ☐ Yes 2 ☐ No  |   | nant at time of c                   |                       | ☐ Ectopic pregnand ☐ Other (specify) _                         | су                        |                            |                                    |                          | Month                      | Day Yea   | ar      |
| P.O.                | that the<br>ed by th<br>detache  | Phy               | 9 ☐ Unknown  Part II. Other significant condition                                   |   |                                     | ulting in the I       | enderlying cause di  | ven in Part               | н                          | 23e Dio                            | Itobacco                 | use contribute             | to the cause of deat                                      | th?     |
|                     | requires t   | d by              | Taren. Other digital condition  | is contributing to de                   | our but not resi                    | anding in the t       | machying dadse gr  | ven in r are              | . 1.                       |                                    |                          |                            | Probably 4 Unk  |         |
| 0                   | law req<br>as beer<br>2 shoul  | Completed         |   |   |                                     |                       |  |                           |                            | 24a. Wa                            | ıs an                    | 24b. Were                  | autopsy findings ava                                      | ailable |
| "Be                 | The la<br>ate has  | dmo               |   |   |                                     |                       |  |                           |                            | per                                | opsy<br>formed?<br>2 ☐No | death'                     | autopsy findings ava<br>o completion of caus<br>es 2 □ No | se of   |
| Mason<br>of Vital F | sian:<br>ertifica<br>ctor, p   | Be C              | 25. Was case referred to medical examiner?  |   |                                     |                       |  | 26. Plac                  | ce of Death                | 1 □Yes<br>(Check only              |                          | <u>ы</u> пынк              | :S 2   NO   |         |
| of V                | Physician:<br>this certific  |                   | 1 Yes 2 No  |   | npatient 2                          |                       | IN 3 L DOA   |                           |                            |                                    |                          | 6 □Other (Sp               | pecify)   |         |
| _                   | ding F   | ion:              | 27. Manner of Death 1 ☐ Natural 5 ☐ Pending   |   | of Injury<br>th, Day, Year)         | 28b. Time o<br>Injury | Wo   | ıryat<br>rk?<br>∃Yes 2.⊑  |                            | 28d. Describe                      | e how inju               | iry occurred               |   |         |
| Ulleem Division     | Attending r death. sctor: After oy the fune  | ficat             | 2 Accident investiga 3 Suicide 6 Could no   |   | of Injury - At ho                   | ome, farm, st         | reet, factory, office  |                           |                            | 28f. Location                      | (Street a                | nd Number or               | Rural Route Number  | r.      |
| William<br>Division | al or safter   | Certification: To | 4 ☐ Homicide determin   | buildi                                  | ng, etc. <i>(Specif</i>             | y)                    |  |                           |                            | City or To                         | own, Stat                | e)                         |   |         |
| 3                   | To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as $\frac{\lambda}{\lambda}$ |                   | (Check only 2 Medical E   | Physician: To the<br>xaminer: On the b  | asis of examina                     |                       |  |                           |                            |                                    |                          |                            |   |         |
|                     | To the within 2 To the I Complet   | Medical           | one) 29b. Signature and title of certifier  | and man                                 | ner stated.                         |                       | 29c. Licen   | se number                 | r                          |                                    | 29d. Da                  | ate signed (Mo             | oth. Dav. Year)   |         |
|                     | F > F S/X  |                   | 1 < 101   | 20                                      |                                     |                       | Itao   |                           | VS                         |                                    | 51                       | 12/20                      |   |         |
|                     | Jx, P  |                   | 30. Name and address of person w  | who completed caus                      | e of death (Iten                    | n 23a) (Type          | Print)   |                           | -                          |                                    |                          | 100                        |   |         |
| _                   | v  |                   | Michael Felder  | IOUE.C                                  | curvoll                             | 5t. S                 | ixlisbury  | , md,                     | 2180                       | 1                                  |                          |                            |   |         |
|                     | Sta<br>Registr   |                   | 31. Date filed (Month, Day, Year)  MAY 1 4  | 2008                                    | egistrar's Signa                    | ture                  | rester   | •                         |                            |                                    |                          |                            |   |         |
|                     | negisti  | aı                | M// 14  |   |                                     | -                     |  |                           |                            |                                    |                          |                            |   |         |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 9:03  $a^{M}$ May 12, Gladys Marie Meredith 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Finksburg 2923 Carrollton Road Carroll Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 🖫 F Director 236-48-6023 9-23-1934 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notified at Finksburg Carroll 1 ☐ Yes 2 ☑ No Director Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21048 2923 Carrollton Road Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 customer service Walmart 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ed Anderson Lovie Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edgar N. Meredith, husband 2923 Carrollton Rd., Finksburg, Md. 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1√ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) May 16, 2008 Crest Lawn Memorial Marriottsville, MD. 22. Name and Address of Facility
Eline Funeral Home
934 S. Main Street, Hampstead, Md. 21. Signature of Funeral Service Licensee 10 21074 Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the list of the lis Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 METAST 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No certificate has b 24a. Was an autopsy performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No Certification: To this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manne Death 1 Matural

Division or Vital Records, P.O. Box 68760,

or Attending Physician: After ours after death.

neral Director: A

filled in by the fu To the Hospital

within 24 hours af

To the Funeral E

completely filled i

DHMH 17 Rev 1/2001

State

Medical

5 ☐ Pending investigation

6 Could not be determined

MAY 1 3 2008

and title of certifier

2 Accident

3 Suicide

29a. Certifier

30. Name

4 Homicide

(Check only one) 29b. Signat

31. Date filed (Month, Day, Year)

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

completed cause of death (Item 23a) (Type, Print)

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 within 24 hours after death.

To the Funeral Director: /

> State MAY 13 Registrar

29a. Certifier

29b. Signature and title of certifier

Yousuf A. Gaffar, 31. Date filed (Month, Day, Year)

30. Name and address of person who completed caus

death (Item 23a) (Type, Print) 555 Sou TH egiarar's Signature 2008

29d. Date signed (Month, Day, Year)

CENTER Street

Certificate of Death

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Month Ruth V. Hooper Moore 12, 2008 12:07 p M May /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital of Cecil County Cecil Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🖸 F 213-10-1690 Maryland Director March 31, Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Cecil Charlestown 1 ☐Yes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 48 Clearview Avenue 21914 U.S.A. items 23a Pages 1 and 2 should be filed within 72 hours after death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 14. Race - American Indian, 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced White Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) one year permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Many once. Homemaker Personal Residence 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oliver W. Strong Cora Mary Jackson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William D. Hooper, Jr. (son) 2503 Rochelle Drive, Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A. Ferris & Co., Inc. 05/16/08 West Chester, Pennsylvania 21. Sign are of Funeral Service Licensee 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. IN TOURSEDING Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCHOLA **Physician** /Medical Due to (or as a consequence of): **Examiner** OSONA Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed ~ CLAC burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpatient 3 DOA P this 27. Mariner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29c. License number 29b. Signature and title of certifier 1.) 30. Name and address of person who completed cause of, death (Item 23a) (Type, Print)

State

Registrar

insth

31. Date filed (Month, Day, Year)

0.

MAY 1 4 2008

|         |   |                | 1 - For<br>State<br>Registrar   | State of   | f Marylan                         |                        | artment of F<br>rtificate of            |                                 | nd Mental H                                  | ygiene<br>Reg. No. | 2008                                     | 17440  |
|---------|---|----------------|---|--|-----------------------------------|------------------------|---|---------------------------------|--|--------------------|--|--|
|         | Physici   | an             | 1. Decedent's Name (First, Middle  Marsha Darlene   |  |                                   |                        |   |                                 | 2. Date of I<br>Month                        | Day                |  | 3. Time of Death                                   |
|         | /Medic  |                | 4a. Facility Name (If not institution,  |  | nber)                             |                        | 4b. City, Town, o                       | r Location of I                 | May<br>Death                                 | 12<br>4c.          | 2008<br>County of Death                  | 10:09P M   |
|         | <u>.</u>  |                | 75 Bayview Roa  |  |                                   |                        | Chesape                                 | eake Ci                         |  |                    | Cecil                                    |  |
|         | Funeral<br>Director   |                | 5. Social Security Number 526-98-6211   | 6. Sex<br>1 ☐ M 2 💢 F                                  | 7. Age (In yrs.                   | last birthday) 55 Yrs. | If Under 1 Year<br>Months Days          |                                 | Min. (Month, I                               | Day, Year)         | Cour                                     | **   |
|         | D   |                | Usual Residence of Decedent   |  |                                   |                        |   |                                 | Dec.   | 24,19              |  | many   |
|         | larylar<br>show   | j.             | 10a. State 10b. County  |  | 10c. Cit                          | y, Town or Lo          | cation                                  |                                 |  |                    | 1  | 0d. Inside City Limits 1 ☐ Yes 2 No                |
|         | the M   | Director       | Maryland Ceci  10e. Street and Number   | 1  | Ch                                | esapea                 | ke City  10f. Zip Code                  |                                 |  | 10g. Citi          | izen of What Cour                        | - 10   |
|         | th with<br>23a or<br>ist be   | al Di          | 75 Bayview Road   | d  |                                   |                        | 21915                                   |                                 |  | Uni                | ted Stat                                 | es   |
|         | tems  | Funeral        | 11. Marital Status  | Armed Fo   |                                   | .S. 13.                | Was Decedent of H                       | lispanic Origin<br>an, Mexican, | n? (Specify Yes or N<br>Puerto Rican, etc.)  |                    | 14. Race - Americ<br>Black, White,       | an Indian,   |
| 200     | ırs afte<br>at", or i<br>xamir  | by F           | 1 ☐ Never Married 2 ☑ Marri<br>3 ☐ Widowed 4 ☐ Divorced   | ed 1 ☐ Yes<br>If Yes, Giv<br>Year or Da                | e                                 |                        | 1 □ Yes 2 🛱 No                          | Specify:                        |  |                    | Specify: Whit                            | e  |
| 5       | 72 hou<br>nature<br>lical E   | ted            | 15. Decedent<br>(Specify only highes  |  |                                   | 16a. Dece              | dent's Usual Occup                      | oation                          | of working                                   | 16b. Ki            | ind of Business/Ind                      | dustry   |
| 4       | vithin "ane.<br>than "a   | Completed      | Elementary/Secondary (0-12)   | College (1   | -4or 5+)                          |                        | kind of work done<br>DO NOT use retire  |                                 | , working                                    |                    |  |  |
| מ       | filed v<br>Hygie<br>other t   |                | 17. Father's Name ( <i>First, Middle, I</i>   | Last)  |                                   | Progr                  | am Direct                               |                                 | s Name (First, Midd                          |                    | <u>profit</u><br>Surname)                |  |
| ā       | uld be<br>Aental<br>rked c<br>ric ev  | To Be          | Lawrence B.H.   | Young  |                                   |                        |   | Anni                            | ie_June_Jo                                   | ohnso              | n  |  |
|         | 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. Health and Mental Hyglene. Are Z7 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at                                  |                | 19a. Informant's Name/Relationsh  |  |                                   | 19b. Mailir            | ng Address (Street                      | and Number                      | or Rural Route Nun                           | ber, City o        | or Town, State, Zip                      | Code)  |
| ָ<br>ע  | 1 and<br>Health<br>em 27  |                | Carl Mazza/husl 20a. Method of Disposition  | oand   | 20b. F                            | Place of Disno         | sition (Name of                         | -                               | Sapeake C:                                   |                    | MD 21915<br>ocation - City or To         | own, State   |
|         | Pages<br>ent of<br>nt: If it  |                | 1 ☐ Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp  |  | State R.                          | remetery, crei<br>Fga  | natory or other pla<br>rd Funer a<br>A• | ce)<br>11                       | 5-14-2008                                    |                    |  |  |
| all     | perm t. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                | 21. Signature of Funeral Service I  |  |                                   | 22                     | 2. Name and Addre                       | ess of Facility                 | R.T. Foan                                    | d Fu               | neral Ho                                 | me, P.A.   |
|         | 9 9 E E P   | -              | frank (.  | ////   | 4/8                               | 3                      | 18 George                               | St.,                            | Chesapeal                                    | ce Ci              |  | 1915   |
|         | KA K  | ķ,             | 23a. Part1 Enter the disease, or shock, or heart failure. List Immediate Cause (Final                       | complications that con<br>only one cause on e          | aused the deat                    |                        | 10                                      | _                               |  | arrest,            | -  | Approximate<br>Interval Between<br>Onset and Death |
|         | Physician<br>/Medical   |                | disease or condition<br>resulting in death)   | a. Due to (  | or as a conseq                    | uence of):             | 1                                       | anc                             |  |                    |  |  |
|         | Examiner  |                | Sequentially list conditions.   | b  |                                   |                        |   |                                 |  |                    |  |  |
| -       | ted sit   | Examiner       | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury | Due to (   | or as a conseq                    | uence of):             |   |                                 |  |                    |  |  |
| 5       | execuin and ial-trai  | Exar           | that initiated events<br>resulting in death) Last   | c<br>Due to (  | or as a conseq                    | uence of):             |   |                                 |  |                    |  |  |
| 0,00    | The law requires that the death certificate be executed atterhas been signed by the attending physician and bage 2 should be detached for use as the burial-transit   | dical          |   | d  |                                   |                        |   |                                 |  |                    |  |  |
| 5       | death certifica<br>attending ph   | Physician/Med  | IF FEMALE:  | 23c. If yes, out                                       | come of pream                     | ancv                   |   |                                 |  | [0                 | 001 Date of 1 1                          |  |
|         | death<br>atten  | ician          | 23b. Was decedent pregnant<br>in the past 12 months?<br>1 ☐ Yes 2 No  | 1 ☐Live b<br>4 ☐ Pregn                                 | irth 2 ☐ Feta<br>ant at time of d | ıl death 3 [           | Ectopic pregnanc<br>Other (specify)     | y<br>                           |  | . ]                | 23d. Date of delive<br>Month             | ery<br>Day Year                                    |
|         | at the by the   | hys            | 9 Unknow  | 9□Unkno  | wn                                |                        |   |                                 |  |                    |  |  |
| ָה<br>מ | w requires that the dispersion by the should be detached  | δ              | Part II. Other significant conditio   | ns contributing to de                                  | ath but not res                   | ulting in the u        | nderlying cause giv                     | en in Part I.                   |  | ,                  |  | he cause of death?<br>Dably 4 ☐ Unknown            |
| 5       | w requ  | eted           |   |  |                                   |                        |   | <del></del>                     | 24a. Wa                                      | `                  |  | ppsy findings available                            |
|         | ding Physician: The lav<br>n.<br>Affer this certificate has<br>funeral director, page 2 :   | Completed      |   |  |                                   |                        |   |                                 | — au pe                                      | opsy<br>formed?    | prior to co                              | mpletion of cause of                               |
| ,       | ertifica<br>ctor, p   | BeC            | 25. Was case referred to medical examiner?  |  |                                   |                        |   |                                 | 1  Yes<br>of Death (Check only               |                    | 1 □ Yes                                  | 22/140   |
| 5       | Physic<br>this or   | 은              | 1 ☐ Yes 2 No 27. Manner of Death  | Hospital: 1 ☐ II                                       |                                   | ER/Outpatier           |   | 4 □ Nurs                        |  |                    | 6 □Other (Specif                         | y)   |
| 5       | nding<br>th.<br>:: After<br>:: fune   | tion           | 1 Natural 5 Pending 2 Accident investig   | (Mont  | h, Day Year)                      | Injury                 | Wor                                     | k?<br>Yes 2∐No                  | 28d. Describ                                 | e now injur        | ry occurred                              |  |
| 2       | r Atter<br>er dea<br>irector  | Certification: | 3 Suicide 6 Could n<br>4 Homicide determi   | nad   Zoe, Flace                                       | of injury - At ho                 | ome, farm, str         | eet, factory, office                    |                                 |  | (Street an         | nd Number or Rura                        | al Route Number,                                   |
| 2       | pital o   |                | 200 Contifier 17 Contificier  | - Physician To the                                     | boot of my line                   | uuladaa daat           | a consumed at the sti                   |                                 |  |                    |  |  |
|         | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director; t  | edical         | 29a. Certifier 1 Certifying (Check only one) 1 Medical E  | g Physician: To the<br>Examiner: On the ba<br>and manr | asis of examina                   | tion and/or in         | vestigation, in my                      | me, date and<br>opinion, death  | place, and due to tr<br>noccurred at the tim | e, date and        | ) and manner as s<br>d place, and due to | tated.<br>o the cause(s)                           |
|         | To th<br>within<br>To th<br>comp  | Me             | 29b. Signature and title of certifier   |  |                                   |                        | 29c. Licens                             |                                 |  | 29d. Dat           | te signed (Month,                        | Day, Year)   |
|         |   |                | () () s   | ک ا  |                                   | W                      |   | 056                             | 449  | -                  | 5/13/                                    | 8  |
|         | 12  |                | 30-Name and address of person v   | vno completed caus                                     | e or death (Iten                  | 1 23a) (Type.          | tish St                                 | Sur                             | 1e 302                                       | EIL                | Jan Mr                                   | 021921   |
|         | Sta<br>Registr  |                | 31. Date filed (Month, Day, Year)   | 2008 32. R   | distrar's Signa                   | ature                  | Carle                                   |                                 | -  |                    | 11-23                                    |  |
|         | เาะยูเจน  | er.            |   |  |                                   |                        |   |                                 |  |                    |  |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 744 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 21:53 1 Mai /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Hospita Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🛛 F 67 Yrs 215-46-1639 Director Nov. 18, 1940 Ireland Usual Residence of Decedent 10a, State 10c. City, Town or Location show 10h. County 10d. Inside City Limits a or 28a-f show t be notified at MD Anne Arundel Arnold Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 789 David Drive 21012 USA ed other than "natural", or items 23a event, the Medical Examiner must be death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Daniel Mahon Agnes Dooner ဥ traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any Injury or other tra Kevin McDermott/ husband 789 David Drive Arnold, MD 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State May 13, 1 ☐ Buriai 2 XCremation 3 ☐ Removal from State Metro Crematory Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 meral Service License Barranco & Sons, Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part? Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pulmomany Immediate Cause (Final Physician Hupertension disease or condition resulting in death) /Medical Due to (or as a cons uen e Examiner Sequentially list conditions, if a year of good cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of) Examine The law requires that the death certificate be executed and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-P.O. Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 2 No 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No has e 2 autopsy performed Yes 2 page certificate 1□ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes Certification: To 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1XX Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Res-000 "Wiphani wuman Do.

State Registrar

Registrar MAY 1 3 2008

Stephani Simon

Streve & Sporte

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

Johns Hupkins Hospital 600 North Wolfe Street, Baltimore, Manyland 21287

|              |  |                     | For<br>State<br>Registrar   | State o                     | f Marylan  | d / Depa<br><i>Cei</i>                      | irtment of H<br>tificate of L                                     | ealth and I<br>D <i>eath</i>     |  | iene 2 0                     | 80                    | 17442  |
|--------------|--|---------------------|---|-----------------------------|--|---|---|----------------------------------|--|------------------------------|-----------------------|--|
| 2            | Physici<br>/Medi   |                     | Decedent's Name (First, Middle, L<br>Elizabeth  | Bertha                      |  | 1alone                                      |   |                                  | 2. Date of Deal<br>Month<br>May 20       | ), 2008                      | Year                  | 3. Time of Death<br>7:00 am M                      |
|              | Examir   | ner                 | 4e. Fecility Name (If not institution, gi<br>Devlin Manor Nu  |                             |  |   | 4b. City, Town, or Cumber   |                                  | ר  | 4c. County of                |                       |  |
|              | Funeral<br>Director  |                     | 5. Social Security Number 6. 214-07-4365  | Sex<br>1 □ M 2 □ <b>X</b> € | 7. Age (In yrs.<br><b>95</b>                       | last birthday)<br>Yrs.                      | If Under 1 Year<br>Months Days                                    | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Worth, Day<br>Oct 23 | , <sup>r</sup> 1912          | 9. Birthp<br>Coun     | lace (State or Foreign                             |
|              | Aaryland<br>Febow  | ō                   | Usual Residence of Decedent  10a. State 10b. County  Allega   | any                         | 10c. Cit   | y, Town or Lo<br>Cum                        | cation<br>berland   |                                  |  |                              | 1                     | 0d. Inside City Limits                             |
|              | with the N<br>or 28a-  | Direct              | 10e. Street and Number 1314 Oldtown Ro  | nad                         |  |   | 10f. Zip Code   | 21502                            | 1  | 0g. Citizen of W             |                       | try?   |
| 30           | be filed within 72 hours after death with the Maryland tat Hygiene. d other then "natural" or items 23e or 28e-f ehow event, it a Meulcal Exeminer must be notified at | by Funeral Director | 11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  |                             | 2 XNo<br>/e  |   | Vas Decedent of Hi<br>I Yes, specify Cuba                         |                                  | pecify Yes or No-<br>o Rican, etc.)      | 14. Race                     | - Americ<br>c, White, |  |
| 1215-0036    | filed within 72 hour<br>Hygiene "natural<br>Ather then "natural<br>ent, I'm Medical Ed   | Completed t         | 15. Decedent's Elementary/Secondary (0-12)  | ducation                    |  | 16a. Deced<br>(Give<br>life. L              | lent's Usual Occupa<br>kind of work done of<br>OO NOT use retired | ation<br>furing most of wor<br>) | rking                                    | 16b. Kind of Bus             | siness/Inc            | dustry   |
| yiand 2      |  | To Be Co            | 17. Father's Name (First, Middle, Las<br>Adam Eric Fro  |                             |  | 00.00                                       |   |                                  | ne (First, Middle, I                     | Maiden Sumame                | _                     |  |
| Mar          | and 2 should by<br>ealth and Menta<br>n 27 Is marked   |                     | 19a. Informant's Name/Relationship Gary Fros.t  | (Турө, Print)<br><b>n</b> e | ephew  | 19b. Mailir<br>534                          | g Address (Street a<br>National Hw                                | und Number or Ru<br><b>y</b> .   | ral Route Number<br>LaVal                | City or Town, S              | State, Zip<br>MC      | <sup>Code)</sup><br>21502                          |
| Baitimore,   |  |                     | 20a. Method of Disposition  1   |                             | State Hill   | Place of Dispo<br>emetery, cren<br>crest Me | sition (Name of<br>natory or other place<br>morial Park           | 9)                               | Date 5/22/2008                           | 20c. Location - C<br>Cumbe   |                       |  |
| Bait         | permit. Pages 1 Department of H Importent: If itel any injury or oth   |                     | 21. Signature of Fun ral Service Lice   |                             |  | 22  | Name and Address  |                                  | łome, PA<br>le: Cumber                   | land MD                      | 21502                 |  |
| e e          | Physician<br>/Medical  |                     | 23a. Fart1. Enter the disease, or construction or heart failure. List only Immediate Cause (Final disease or condition resulting in death)                | one cause on e              | ach line.  | milin                                       |   | g, such as cardiad               | or respiratory arr                       | est,                         |                       | Approximate<br>Interval Between<br>Onset and Death |
| ů,           | Examiner   | Examiner            | Sequential, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. — Due to t               | or as a consequor as a consequor as a consequor    | uence of):                                  |   |                                  |  |                              |                       |  |
| U. BOX 68/6U | at the death certificate be executed<br>by the attending physician and<br>tached for use as the burial-transit   | Physician/Medical   | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown   | 1 Live b                    | come of pregna<br>irth 2 Feta<br>ant at time of do | Ideath 3                                    | Ectopic pregnancy   |                                  |  | 23d. Date<br>Mon             |                       | ory<br>Day Year                                    |
| J.           | ss that<br>gned b  | by                  | Part II. Other significant conditions   | contributing to de          | eath but not res                                   | ulting in the u                             | nderlying cause give  | en in Part I.                    |  |                              | bute to th            | e cause of death?                                  |
| Hecords,     | e law<br>has b   | Completed           |   |                             |  |   |   |                                  | 24a. Was a autops perfori                | in 24b. W                    | Vere auto             | psy findings available<br>appletion of cause of    |
| Vitai        | sician:<br>certific<br>rector  | Be                  | 25. Was case referred to medical examiner?  | Hospital:                   |  |   | Othe  | NP:                              | ath (Check only on                       |                              |                       |  |
| on or        | iding Physith.<br>The After this funeral di  | tion: To            | 1  Yes 2  → Ho  27. Manner of Death 1  Natural 5  Pending 2  Accident investigati   | 28a. Date (Mont             |  | ER/Outpatien<br>28b. Time of<br>Injury      | 28c. Injury<br>Work   | 4 - Harsing F                    | lome 5 Reside                            |                              |                       | /)   |
| DIVISION     | of or Attendate after death Director;  | Certification:      | 3 Suicide 6 Could not determine   | 28e. Place                  | of Injury - At hong, etc. (Specif                  | ome, farm, str                              | eet, factory, office  |                                  | 28f. Location (St<br>City or Town        | treet and Numbe<br>n, State) | or or Rura            | l Route Number,                                    |
|              | To the Hospitel or Attending within 24 hours after death.  To the Funeral Director; After completely filled in by the funer  | edical C            | 29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa  | miner: On the ba            | asis of examina<br>ner stated.                     | tion and/or in                              | occurred at the tim<br>restigation, in my of                      | oinion, death occu               | irred at the time, d                     | ate and place, a             | nd due to             | the cause(s)                                       |
|              | To th<br>within<br>To th<br>compl  | Me                  | 29b. Signature and title of certifier   | '/ "                        | 7  |   | 29c. License  | number                           | 2  | 9d. Date signed              | (Month,               | Day, Year)   |
|              |  | 1                   | 30. Name and address of person who  | completed caus              | se of death (Item                                  | n 23a) (Type,                               | 29c. License 70 0   | 10/156                           |  | Wash                         | 26,                   | 2008   |
|              |  |                     | / 1211 [110   | 12 B                        | 9 上 シ ル<br>egistrar's Signa                        | 2+1   | 1st wy  | L2011                            | e, 170                                   | 2180                         | 12                    |  |
|              | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year) MAY 2 9 2   | 008                         | ogistiai s signa                                   | Lang  | (K)   |                                  |  |                              |                       |  |

ORIGINAL

|  |                              | Registrar  1. Decedent's Name (First, Middle   | , Last)   |   | 001   |   | Death  | 2. Date of   |   |  | 3. Time of Deat   |
|--|------------------------------|--|---|---|---|---|--|--|---|--|---|
| Physicia:<br>/Medica   | _                            | Donald Lee   | Moser   |   |   |   |  | Month  | 2 <sup>Da</sup>   | ් <i>බ</i> ්රීම්   | 6:40A   |
| Examine  |                              | 4a. Facility Name (If not institution  | , give street and numb  | er)   |   | 4b. City, Town, o   | r Location of De   | eath   | 4c.   | County of Death  | 1   |
|  |                              | Washington Cou   | unty Hospi  |   |   | Hagerst   |  | lro la p   |   | ashingto   |   |
| eral<br>ctor   |                              | 5. Social Security Number 220–28–3209  | 6. Sex 7.   | Age (In yrs. I  | ast birthday) L<br>Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 F<br>Hours M   | in. (Month,  | Day, Year)  | 9. Birth<br>Cod<br>932 Mary  | nplace <i>(State or For</i><br>untry)<br>v <b>1 and</b> |
| Case of  |                              | Usual Residence of Decedent  10a. State 10b. County  |   | 10c, Cit  | , Town or Loc   | ation   |  | 11100  |   |  | 10d. Inside City Lin                                    |
| any injury or other traumatic event, the Medical Extrainment be notified at once.  | .                            | Maryland Washing   | ~ton  |   | erstown   |   |  |  |   |  | 1 Yes 2 □   |
|  |                              | 10e. Street and Number   | <u>ś</u> . CO11   | паде  | EISLOWI   | 10f. Zip Code   |  |  | 10g. Cit  | izen of What Co  | untry?  |
|  | era l                        | 115 Harvard Rd.  |   |   | T   | 21742   |  |  | U.S.  |  |   |
|  | Funeral                      | <ol> <li>Marital Status</li> <li>Never Married 2  Marrie</li> </ol>  | 12. Was Decede<br>Armed Force<br>ed 1 Tes 2   | es?   | 5.   13. W  | as Decedent of l<br>Yes, specify Cub  | Hispanic Origin?<br>an, Mexican, Pu  | (Specify Yes or lerto Rican, etc.)                                   | No-   | 14. Race - Amer<br>Black, White  |   |
|  | 2                            | 3 Widowed 4 □ Divorced   | Yes, Give<br>Year or Date   |   | 1   | □Yes 2No  | Specify:   |  |   | Specify: Whi   | te  |
|  | Completed                    | 15. Decedent'<br>(Specify only highes  | 's Education<br>t grade completed)  | - 1   | 16a. Deced  | ent's Usual Occu<br>ind of work done<br>O NOT use retire  | oation<br>during most of v   | vorking  | 16b. K  | ind of Business/I  | ndustry   |
|  | dwo                          | Elementary/Secondary (0-12)  | College (1-4d   | or 5+)  |   |   |  |  | 177   |  |   |
|  | ي -<br>ک                     | 17. Father's Name (First, Middle, L  | _ast)   |   | Equip   | ment Op   |  | Name (First, Midd  |   | ood_serv<br>Surname)   | rice  |
| 3 1  | 0                            | Russell Lewis N  | loser   |   |   |   | Agnes  | Lucinda  | Youn  | kins   |   |
| 3 5  | ij                           | 19a. Informant's Name/Relationsh   |   |   | 1   |   |  | Rural Route Nur  | -   |  |   |
|  | - 23-                        | Delores Kline / 20a. Method of Disposition   | sister  | 20b. P  |   |   |  | onsboro  |   | cation - City or   |   |
| 5 2  |                              | 1 Burial 2 ☐ Cremation<br>4 ☐ Donation 5 ☐ Other (Sp   | 3 Removal from Sta  | ate   |   | ition (Name of<br>atory or other pla  | i  |  |   | ,  |   |
| ė  | 1                            | 21. Sig Ture f Funeral Service   |   | Kest  |   | Cemeter Name and Addre  |  | 27/2008<br>Rest Have   |   |  | Marylan<br>anel   |
| any ii   |                              | En 7   | 1   |   | 16  | 01 Penns  |  |  |   |  | ryland 2  |
|  |                              | 23a. Part1. Enter the disease, or o shock, or heart failure. List of   | complications that causonly one cause on eac  | sed the death<br>h line.  | . Do not ente   | r the mode of dy  | ng, such as card   | diac or respiratory  | y arrest,   |  | Approximate<br>Interval Betwee<br>Onset and Dea         |
| ian  | 1                            | Immediate Cause (Final disease or condition resulting in death)  | a. Jer  | 515   |   |   |  |  |   |  | 17-6-   |
| ical<br>iner   |                              | , ssaling in assum,  | Due to (or  | as a consequ  | ience of):  | 1.0   | 1  |  |   |  | send dy   |
|  | je                           | Sequentially list conditions, if any, leading to immediate cause. Elter Underlying Cause (Disease or injury  | b. Due to (or   | as a consequ  | ience of):  | delight   | -  |  |   |  | year ay   |
| s the burial-transit   | Examiner                     | Cause (Disease or injury<br>that initiated events<br>resulting in death) Last  | c   |   |   |   |  |  |   |  |   |
|  |                              | resulting in death) Last   | Due to (or  | as a consequ  | ence of):   |   |  |  |   |  |   |
| 3  | edical                       |  | d   |   |   |   |  |  |   |  |   |
|  |                              | IF FEMALE:<br>23b. Was decedent pregnant   | 23c. If yes, outcome  |   |   |   |  |  |   | 23d. Date of deli  | very  |
|  | Physician/IM                 | in the past 12 months?<br>1 ☐ Yes 2 ☐ No   |   | th 2□Fetal<br>nt at time of de  |   | Ectopic pregnan<br>Other (specify) _  | су   |  |   | Month  | Day Year  |
| 3  | ج<br>چ ا                     | 9 Unknown  |   |   | Min in Mr.  | d-uk.t  | i- DAl   | 22a Di   | d tobacco   | use contribute to  | the cause of death                                      |
|  | 2                            | Part II. Other significant condition   | =   |   | _   | aeriying cause gi   | en in Part I.  |  |   |  | obably 4 13 Unkr  |
| i   i  |                              | aquestion  | new.  |   |   |   |  | 24a, W   |   |  | topsy findings avail                                    |
| i  | ere                          |  |   |   |   |   |  | — au<br>pe   | topsy<br>rformed?   | prior to death?  | ompletion of cause                                      |
| i i  | ornpiete                     |  |   |   |   |   |  | 1 ∐Yes   | 2 2 No  | 1 ∐Yes   | 2 🗆 No  |
| in potological   | se Completed                 | 25. Was case referred to medical   |   | -ocar oc  |   |   | 26. Place of D   | Death (Check on)   | v one)  |  |   |
| o Do O completed by  | Re                           | 25. Was case referred to medicalexaminer? 1 ☐ Yes 2 ☑ No   | Hospital: 1 ☐ Hinp  | atient 2 🗆 I  | ER/Outpatient   | 3 □ DOA Oth   |  | Death <i>(Check</i> on <i>l</i><br>g Home 5 ☐ Re                     |   | 6 □Other (Spec   | cify)   |
| To Do Completed by   | 10 Be                        | examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending  | 28a. Date of I<br>(Month,   |   | ER/Outpatient<br>28b. Time of<br>Injury   | 28c. Inju   | ner: 4 Nursin<br>ry at<br>k?   |  | esidence  |  | oify)   |
| To Do Completed by   | 10 Be                        | examiner?  1 Yes 2 H00  27. Manner of Death  1 Natural 5 Pending  2 Accident investigs  3 Suicide 6 Could n  | 28a. Date of (Month, ation of be  | Injury<br>Day, Year)  | 28b. Time of<br>Injury  | 28c. Inju   | ner: 4 🗆 Nursin  | g Home 5  Re<br>28d. Describ   | esidence<br>e how injur   | ry occurred  |   |
| ord Endelman Court of the Polymer Court of the Poly | 10 Be                        | examiner?  1 Yes 2 HO  27. Manner of Peath 1 Natural 5 Pending 2 Accident investige  | 28a. Date of (Month, ation of be 28e. Place of  | Injury<br>Day, Year)  | 28b. Time of Injury   | 28c. Inju   | ner: 4 Nursin<br>ry at<br>k?   | g Home 5 Re 28d. Describ   | esidence<br>e how injur   | ry occurred<br>and Number or Ru  |   |
| To Do Completed by   | Certification: 10 Be         | examiner?  1 Yes 2 Ho  27. Manner of Death  1 Natural 5 Pending investigs  3 Suicide 6 Could ndeterming  4 Homicide 1 Certifying   | 28a. Date of I (Month, ation of be ned 28e. Place of building,  | Injury Day, Year) Injury - At hor, etc. (Specify est of my know                           | 28b. Time of Injury  me, farm, stre  //   | 28c. Inju Wo 1  | er: 4 □ Nursin<br>ry at<br>k?<br>]Yes 2 □ No   | g Home 5  Re 28d. Describ 28f. Location City or 1                    | esidence  e how injur  (Street ar  Fown, State                                | ory occurred  and Number or Ru  b)  and manner as                              | ral Route Number,                                       |
| To Do Oceanista his  | legical Certification; to be | examiner?  1 Yes 2 No  27. Manner of Peath 1 Natural 5 Pending investige investige 6 Could not determine 1 Check only one)   | 28a. Date of (Month, ation of be ned 28e. Place of building,  | Injury Day, Year) Injury - At hor, etc. (Specify est of my know is of examinat            | 28b. Time of Injury  me, farm, stre  //   | 28c. Inju Wo M 1 Cet, factory, office   | ner: 4 ☐ Nursingry at K?  Yes 2 ☐ No  ime, date and plopinion, death o   | g Home 5  Re 28d. Describ 28f. Location City or 1                    | esidence the how injure the (Street are Fown, State) the cause(stee, date and | nd Number or Ru  a)  a)  and number or Ru  b)  and manner as  d place, and due | ral Route Number, stated. to the cause(s)               |
| Contification To Do Commission by  | legical Certification; to be | examiner?  1 Yes 2 No  27. Manner of Peath 1 Natural 5 Pending investige investige 6 Could n. determing the period of the period | 28a. Date of I (Month, ation of be ned 28e. Place of building, g Physician: To the be examiner: On the basic  | Injury Day, Year) Injury - At hor, etc. (Specify est of my know is of examinat            | 28b. Time of Injury  me, farm, stre  //   | 28c. Inju Wo M 1 Eet, factory, office   | ner:  4  Nursing ty at k?  Yes 2 No lime, date and plopinion, death of the number  | g Home 5  Re 28d. Describ 28f. Location City or 1                    | esidence ne how injur n (Street an Fown, State he cause(s ne, date and        | nd Number or Ru  a)  a)  a)  and manner as  d place, and due  te signed (Month | ral Route Number, stated. to the cause(s)               |
| To Do Oceanista his  | Medical Certification: 10 Be | examiner?  1 Yes 2 No  27. Manner of Peath 1 Natural 5 Pending investige investige 6 Could n. determing 29a. Certifier (Check only one)  29b. Signature and title of certifier   | 28a. Date of I (Month, ation of be ned 28e. Place of building, g Physician: To the be and manner  | Injury Day, Year) Injury - At hou , etc. (Specify est of my know is of examinat r stated. | 28b. Time of Injury  me, farm, stre  wledge, death ion and/or inv               | 28c. Inju Wo M 1 = 28c. Inju Wo | ner: 4 ☐ Nursingry at K?  Yes 2 ☐ No  ime, date and plopinion, death o   | g Home 5  Re 28d. Describ 28f. Location City or 1                    | esidence ne how injur n (Street an Fown, State he cause(s ne, date and        | nd Number or Ru  a)  a)  and number or Ru  b)  and manner as  d place, and due | ral Route Number, stated. to the cause(s)               |
| To Do Osmaloted ha   | Medical Certification: 10 Be | examiner?  1   | 28a. Date of land (Month, ation of be ned 28e. Place of building, g Physician: To the becaminer: On the basi and manner who completed cause of  | Injury Day, Year)  Injury - At hole, etc. (Specify est of my know is of examinate stated. | 28b. Time of Injury me, farm, stre ) wledge, death ion and/or inv               | 28c. Inju Wo M 1 Eet, factory, office occurred at the testigation, in my 29c. Licenstrint)  | ner: 4 Nursing | g Home 5  Re 28d. Describ 28f. Location City or 1 ace, and due to to | esidence ne how injur n (Street arrown, State he cause(s ne, date and         | nd Number or Ru  a)  a)  a)  and manner as  d place, and due  te signed (Month | ral Route Number, stated. to the cause(s)               |
| ineral director, page 2 should be d  | Medical Certification: 10 Be | examiner?  1   | 28a. Date of land in ation of be ned 28e. Place of building, g Physician: To the because of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the complete cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the | Injury Day, Year)  Injury - At hole, etc. (Specify est of my know is of examinate stated. | 28b. Time of Injury me, farm, stre ) wledge, death ion and/or inv 23a) (Type, P | 28c. Inju Wo M 1 = 28c. Inju Wo | ner: 4 Nursing | g Home 5  Re 28d. Describ 28f. Location City or 1 ace, and due to to | esidence ne how injur n (Street an Fown, State he cause(s ne, date and        | nd Number or Ru  a)  a)  a)  and manner as  d place, and due  te signed (Month | ral Route Number, stated. to the cause(s)               |
| completely filled in by the funeral director, page 2 should be d   | Medical Certification: 10 Be | examiner?  1 Yes 2 No  27. Manner of Peath 1 Natural 5 Pending investige investige of Peach 3 Suicide 6 Could net determing (Check only one)  29a. Certifier Check only 1 Certifying Nedical Equation (Check only one)  29b. Signature and title of certifier  30. Name and address of person we will be considered.   | 28a. Date of land in ation of be ned 28e. Place of building, g Physician: To the because of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the completed cause of the complete cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the cause of the | Injury Day, Year)  Injury - At hole, etc. (Specify est of my know is of examinate stated. | 28b. Time of Injury me, farm, stre ) wledge, death ion and/or inv 23a) (Type, P | 28c. Inju Wo M 1 Eet, factory, office occurred at the testigation, in my 29c. Licenstrint)  | ner: 4 Nursing | g Home 5  Re 28d. Describ 28f. Location City or 1 ace, and due to to | esidence ne how injur n (Street arrown, State he cause(s ne, date and         | nd Number or Ru  a)  a)  a)  and manner as  d place, and due  te signed (Month | ral Route Number stated. to the cause(s)                |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2008 May 10, Orlando Ore- Manchego 1:20 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours **1** M 2 □ F Months 262-35-3376 59 Director June 19, 1948 Peru Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits la or 28a-f show t be notified at 28a-f show 1 ☐ Yes 2 ☐ No Directo Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19710 Crystal Rock Drive, #13 'natural", or Items 23a 20874 Examiner must Peru within 72 hours after death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 x Yes 2□ No Specify: Peruvian ş Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) the permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumatic event, the ones. Upholsterer Family Business 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lino Ore ပ Rosa Manchego 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Leon Aronez/Wife 19710 Crystal Rock Drive, #13, Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 14, May 1 K Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2008 Silver Spring, Maryland 22 Name and Address of Eacility
Francis J. Collins Funeral none

500 University Blvd, W. Silver Spring, Md 200

Approximate Interval Between Onset and Death 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): **Examiner** INFECTION UNINARY RACT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) be executed burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical the The law requires that the death certificate for use IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by been signe should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ño 1 Empatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

or Attending Physician: Hospital

To the France.

Within 24 hours after death.

To the Funeral Director: Aft

4 Homicide 29a. Certifier (Check only 29b. Signature and title of certifie

Medical

31. Date filed (Month

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

00057124

29d. Date signed (Month, Day, Year) 110100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD 9715 Medical Center Drive, #30, Rockville, MD 20850

State Registrar seo, MD

|                     |  |                     | 1 - For State Registrar  | State of N  | Maryland / Depa  |   | Health and N   | Лental Нус                                 | giene<br>leg. No 20                |                                     | 17445                                       |
|---------------------|--|---------------------|--|---|--|---|--|--|------------------------------------|-------------------------------------|---|
|                     | Physic   |                     | 1. Decedent's Name (First, Middle Aleida   | , Last)<br>T•   | Portuondo  | 1   |  | 2. Date of Dea<br>Month<br>May             |                                    | 0 <sup>Year</sup>                   | 3. Time of Death 2:00pm M                   |
|                     | /Medi<br>Examii  |                     | 4a. Facility Name (If not institution, Manor Care Heal   | give street and numbe   |  |   | or Location of Death<br>Spring   |  | 4c. County                         |                                     |   |
|                     | Funeral<br>Director  |                     | 5. Social Security Number 262-74-7779  | 6. Sex 7. /<br>1 ☐ M 2 🔀 F  | Age (In yrs. last birthday)<br>82 Yrs.   | If Under 1 Year<br>Months Days  |  | 8. Date of Birth<br>(Month, Day<br>June 11 | Year)                              | 9. Birthp                           | lace (State or Foreign<br>try)<br>.na, Cuba |
|                     | Maryland<br>a-f show   | tor                 | Usual Residence of Decedent  10a. State 10b. County  MD Montgo   | mery  | 10c. City, Town or Lo  |   |  |  |                                    | 1                                   | 0d. Inside City Limits 1 Yes 2 No           |
|                     | or 28  | Olrec               | 10e. Street and Number   |   |  | 10f. Zip Code   |  |  | l0g. Citizen of                    | What Coun                           | try?  |
|                     | s 23a  | ral                 | 2501 Musgrove R  |   |  | 2090  | •  |  |                                    | SA                                  |   |
| 980                 | urs after de<br>al', or Item<br>Examinet   | by Funeral Director | 11. Marital Status 1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced  | 12. Was Deceder Armed Forces ed 1 Tyes 2 S If Yes, Give Year or Dates | ₫ No   | Was Decedent of if Yes, specify Cub<br>1 Yes, specify Cub<br>1 Yes 2 □ No | Hispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: Cu   | pecify Yes or No-<br>Rican, etc.)<br>Iban  |                                    | e - Americ<br>ck, White,<br>v: Blac | etc.  |
| Maryland 21215-0036 | be filed within 72 hours after death with the Maryland ital Hygiene. So other than "natural", or Items 23s or 28s-f show event, the Madical Examinal must be natified at | Completed by        | 15. Decedent<br>(Specify only highes<br>Elementary/Secondary (0-12)  | college (1-4o   | r 5+) (Give life.  |   | pation<br>during most of work<br>ed)   | sing                                       | 16b. Kind of B                     |                                     | •   |
| d 2                 | filed v<br>Hygie<br>other t  | e Co                | 17. Father's Name (First, Middle, L  | 5+  | Prof   | essor   | 18. Mother's Name  | e /First Middle                            |                                    | ivate                               |   |
| rylan               | should be<br>and Mental<br>marked o  | To B                | Jose Taamayo  19a. Informant's Name/Relationsh   | in (Type Print)   | 19h Maili  | og Address /Stree   |  | Amador                                     | Pinera                             |                                     | Codel                                       |
| Σ                   | nd 2 sulth ar  |                     | Marie F. Portu   |   |  |   | Dr. Silv   |  |                                    |                                     |   |
| Baltimore,          |  |                     | 20a. Method of Disposition 1   Burial 2 □ Cremation  | 3 □Removal from Stat  | 20b. Place of Dispo<br>cemetery, crer  | sition (Name of<br>matory or other pla                                    | ce)  | Date                                       | 20c. Location -                    | City or To                          | wn, State                                   |
| ţim                 | P DE T   |                     | *4 □Donation 5 □ Other (Sp   | ecify)  | Glenwood   |   | The state of the s |  | Washin                             |                                     |   |
| Bal                 | permit. Departr Imports any inj  |                     | 21. Signature of Funeral Service L   | Lock  |  |   | edy St. N  | W, Washi                                   | ington,                            |                                     | neral Home<br>20011                         |
| 8760,               | Medical Examiner https://www.ician.and https://www.ician.and https://www.ician.and.and.and.and.and.and.and.and.and.a   | Ical Examiner       | 23a Part 1. Enter the disease, of shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the Enterth of the Enterth of Injury that initiated events resulting in death) Last | a. Cere Due to (or a  b. Deme Due to (or a  c. Fail                   | ebrovascular as a consequence of): entia as a consequence of): ure to thri as a consequence of): | acciden   |  |  |                                    |                                     | Interval Between<br>Onset and Death         |
| .O. Box 6           | death certific<br>e attending p<br>od for use as   | Physician/Med       | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown  |   | 2 Fetal death 3  | Ectopic pregnanc  | у  |  | 23d. Da<br>Mo                      | te of delive                        | ry<br>Day Year                              |
| <u>α</u>            | w requires that the de<br>been signed by the a<br>should be detached t   | þ                   | Part II. Other significant condition   | ns contributing to death  | but not resulting in the ur  | nderlying cause giv   | ven in Part I.   |  |                                    |                                     | e cause of death?                           |
| Vital Records,      | The law<br>ate has b<br>page 2 si  | Completed           | 05.1%  |   |  |   |  | 24a. Was a autops perforr                  | ned?                               | prior to con<br>death?              | sy findings available apletion of cause of  |
|                     | Physician:<br>r this certific<br>ral director,   | o Be                | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No  | Hospital: 1  Innat  | tient 2 ER/Outpatien   | Oth   | 26. Place of Death<br>ner: 4 ☑ Nursing Ho  |  |                                    | /0                                  | 1   |
| ion of              | ding<br>h.<br>Afte<br>fune   | atlon: T            | 27. Manner of Death  1 Natural 5 Pending 2 Accident investiga  | 28a. Date of In<br>(Month, D  |  | 28c. Injui<br>Wai   | y at   | 28d. Describe ho                           | ow injury occurr                   | ed ( <i>Specify</i>                 |   |
| Division            | salor Attences after death   | Certification:      | 3 ☐ Suicide 6 ☐ Could no<br>4 ☐ Homicide determin  | 286. Place of It  | njury - At home, farm, stro<br>tc. <i>(Specify)</i>  | eet, factory, office  |  | 28f. Location (St<br>City or Town          |                                    | er or Rural                         | Route Number,                               |
|                     | To the Hospital or Attenwithin 24 hours after deation to the Funeral Director: completely filled in by the   | edical              | 29a. Certifier 1 Certifying (Check only one)   | Physician: To the bes<br>xeminer: On the basis<br>and manner s        | t of my knowledge, death<br>of examination and/or inv<br>stated.                                 | occurred at the til   | me, date and place,<br>opinion, death occurr   | and due to the cared at the time, do       | ause(s) and ma<br>ate and place, a | nner as sta<br>and due to           | ited.<br>the cause(s)                       |
|                     | To the within 2 To the complet   | Σ                   | 29b. Signature and title of certifier  | 1.11  | 11   | 29c. Licens   |  |  | 9d. Date signed                    |                                     | Day, Year)                                  |
| 0                   |  |                     | 20 Name and address of acres   | $\sim$ $w$  | death (Item 22-) (T  | D5928   | 1  | M  | lay 14,                            | 2008                                |   |
| N                   | (6)  |                     | 30. Name and address of person w Dr. Ishiaq Ma1  | ik 106 Irvi   | ing St. NW,  | Washingt  | on, DC 20  | 0010 Nor                                   | th Towe                            | rs Su                               | ite#3000                                    |
|                     | Sta<br>Registr   |                     | 31. Date filed (Month, Day, Year)  MAY 1 5. 2008   | Scene J   | trar's Signatus  |   |  |  |                                    |                                     |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month May Roy 2008 Lee Porter 10:47 pm /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery Betnesua
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Year) 1⊠M 2□F Director 437-56-0858 67 June 28, 1940 Texas Usual Residence of Decedent f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shor Exa all ser must be notified at Director 1 ☐ Yes 2 TNo Maryland Montgomery Chevy Chase 10e. Street and Number 10g. Citizen of What Country? 7108 Brookville Road Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1961-63 1 ☐ Yes 2 K No Specify: \$ Specify: White permit. Pages 1 and 2 should be flied within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, Ir. In addition Exa 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Teacher I.T.T. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 2 Harvey Jackson Porter LulaBelle DeMoss 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Lisa McKinnon</u> 7108 Brookeville Road, Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1₺ Burial 2 ☐ Cremation 3 🕅 Removal from State Laurel Oaks Cemetery 5/17/08 4 ☐ Donation 5 ☐ Other (Specify) Mesquite, Texas 22. Name and Address of Facility Simple Tribute 1040 Rockville Pike, Rockville, MD 20852 23a. Part1. Ento the dise s, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or sart failure. List only one cause on each line. Approximate Interval Between Interval Between Onset and Death HSuunte Immediate C fuse (Final disease or condition resulting in death) **Physician** aspirat 100 precuous /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 ☐ Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ schroplisting 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an The Vital 1 □ Yes 2 No 2. No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA of this 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28d. Describe how injury occurred 1 Natural 5 | Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

To the Hospital of within 24 hours a To the Funeral D completely

Roy

State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

1001

32. Reastrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2003

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

55410

Hergeny Ginclesman

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** V. Powe11 /Medical May 2008 10:40 Α 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Nursing Home Salisbury Wicomico If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 6. Sex Months Days Hours 1 ☐ M 2 🗓 F 216-10-2362 Director 100 2-6-1908 Maryland Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits at notified Director 1 ☐ Yes 2X No 28a-f Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be i 23a 904 Emerald Court death v Funeral 21804 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Completed by Specify: White 1 and 2 should be filed within 72 hours Health and Mental Hygiene. 3 X Widowed 4 ☐ Divorced 'natural" the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked Thomas H. Brittingham မ Ira Townsend 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Kathleen O. Muir - Daughter 904 Emerald Court, Salisbury, MD 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages ō 1 X Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) Salem U. M. Cemetery 5-15-2008 Pocomoke City, MD 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Faheral Service Licensee 705 E. Main Street, Salisbury, Maryland 21804 calons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. 23a. Part . Enter the disease, or complications shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final ASCVO Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed and the burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, aftending physician as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy certificate death? 1∐ Yes 'ELINO or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2☐ No Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA Certification: To 2 ER/Outpatient this filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation **U**H⊒Naturai al Director: / 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital of within 24 hours at To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 63155 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Vohra, MD Yoges 614 Easternshore Drive, Salisbury, MD 21804 13 2008 State Registrar

DHMH 17 Rev 1/2001

Registrar

2008

Division or Vital Records, P.O. Box 68760 To the Hospital or Attending Physician:

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Image: Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State

Medical

31. Date filed (Month, Day, Year)

29b Signature and title of ce

1 3

death (Item 23a) (Type, Print)

Registrar

|   |   |                  | 1 – For<br>State<br>Registrar  | State of Marylan   |                                 | artment of I<br>rtificate of               |   | , ,  | iene<br>eg. No. <b>2</b> : <b>3</b> ( | 8 17650  |
|---|---|------------------|--|--|---------------------------------|--|---|--|---------------------------------------|--|
|   | ysici:<br>Medic   |                  | 1. Decedent's Name (First, Middle, Last)  DDUGLAS  |  | ARKE                            | R  |   | 2. Date of Deat<br>Month<br>Hay                | h<br>Day Y                            | 3. Time of Death   |
|   | amin  |                  | 4a. Facility Name (If not institution, give s No 2th WEST  | Hospital   |                                 | 4b. City, Town, o                          | Procession of Death                                   | 1  | 4c. County of                         | Death  |
| Fun<br>Dire   | eral<br>ctor  |                  | 5. Social Security Number 6. Sex 1 Security Number 1 Security Numb | 7. Age (In yrs. 49   | last birthday)<br>Yrs.          | If Under 1 Year<br>Months Days             | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, Feb 4,           | Year)                                 | Birthplace (State or Foreign<br>Country)<br>Pennsylvania                       |
| Maryland  | fled at   | tor              | 10a. State 10b. County  MD Howard  |  | y, Town or Lo                   |  |   |  |                                       | 10d. Inside City Limits 1 ☐ Yes 2 ☐ No   |
| n with the  | at the noti   | Funeral Director | 10e. Street and Number 773 Chessie Crossi  |  | OCCULIE                         | 10f. Zip Code 21797                        |   | 10   | Og. Citizen of What                   | •  |
| d 21215-0036 filed within 72 hours after death with the Maryland Hygiene. wither than "natural", or Items 23a or 28a-f show   | event, the Medical Examinar must be notified at   | by               |  | 2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:            |                                 |  | dispanic Origin? (S<br>an, Mexican, Puert<br>Specify: | pecify Yes or No-<br>o Rican, etc.)            | 14. Race -                            | American Indian, White, etc.  White  |
| 21215-0036 d within 72 hours aft giene.   | e Medical   | Completed        | 15. Decedent's Educ<br>(Specify only highest grade<br>Elementary/Secondary (0-12)  | completed) College (1-4or 5+)  | (Give<br>life. L                | OO NOT use retire                          | during most of wor.<br>d)                             | king   | 6b. Kind of Busin                     |  |
| d all a   | c event,  | Be               | 17. Father's Name (First, Middle, Last)  Charles David Park  | 5+<br>ser. Sr  | Soft                            | ware Dev                                   |   | ne (First, Middle, N<br>len Serne              | ,                                     | oloyed   |
| M2 stiff a 27 is  | other traumatic   | 7                | 19a. Informant's Name/Relationship (Type<br>Carol Jean Parker/   | pe. Print)   |                                 |  | and Number or Ru                                      | ral Route Number,                              | City or Town, Sta                     |  |
| altimore,<br>rmit. Pages 1 ar<br>spartment of Hea<br>portant: If item   | ury or othe   |                  | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)   | 20b. P   | lace of Dispo<br>emetery, cren  | sition (Name of natory or other place      | ce)   | Date 2   | 20c. Location - Cit                   |  |
| Baltimor permit. Pages Department of Important: If it   | any inju<br>once.   |                  | 21. Signature of Funeral Service Licenses  | With MOIO  | )44   <sup>22</sup>             | Name and Addre                             | ss of Facility Har<br>Columbia 1                      | rry H. Wi                                      | tzke's I                              | Family FH Inc.   |
| Physic<br>/Medi   | ical  |                  | 23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)   | e cause on each line.  | n. Do not ente                  | er the mode of dying                       | ng, such as cardiac                                   | or respiratory arre                            | st,                                   | Approximate<br>Interval Between<br>Onset and Death                             |
| 8 760,<br>ate be executed<br>physician and  | tne burial-transit  | edical Examiner  | Sequentially list conditions, and the sequentially list conditions, and the sequential cause. Enter Undertrying Cause (Disease or injury that initiated events resulting in death) Last  | Due to (or as a consequence to (or as a consequence)   | ,                               |  |   |  |                                       |  |
| <b>BOX</b> (sath certi  | ror use a   | Physician/Med    | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  | cc. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown | death 3 □                       | Ectopic pregnanc<br>Other (specify)        | у   |  | 23d. Date o<br>Month                  | -  |
| law requires that the   | und be deta   | ed by Pr         | Part II. Other significant conditions cont   | ributing to death but not resu   | liting in the un                | derlying cause give                        | en in Part I.   |  |                                       | ite to the cause of death?  ☐ Probably 4 ☐ Unknown                             |
| The The   | n, page z sric  | Completed by     | 05 Western (see the  | 11.  |                                 |  |   | 24a. Was an<br>autopsy<br>perform<br>1 □ Yes 2 | ed? prio                              | re autopsy findings available<br>or to completion of cause of<br>th?<br> Yes 2 |
| r VIII nysicia nis certi  | Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Diselle<br>Disell | To Be            | 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Ho   | ospital: 1 ☑ Impatient 2 ☐ I   | ER/Outpatient                   | 3 □ DOA Othe                               | or:   | th <i>(Check only one</i><br>ome 5 ☐ Resider   |                                       | (Specify)  |
| SION OF<br>tending Phy<br>leath.<br>tor: After this   |   | Certification: 1 | 27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation  | 28a. Date of Injury<br>(Month, Day, Year)  | 28b. Time of Injury             | 28c. Injur<br>Work<br>M 1 🗆                | y at  | 28d. Describe how                              |                                       | <u> Эреспу)</u>  |
| To the Hospital or Attending Physician: within 24 hours after death. The Funeral Director, After this certifical or analysis of the former of | ined in by  |                  | 3 ☐ Suicide 6 ☐ Could not be determined  | 28e. Place of Injury - At hor building, etc. (Specify  |                                 |  |   | City or Town,                                  | State)                                | or Rural Route Number,   |
| ne Hos<br>n 24 ho<br>ne Fund  | :   | Medical          | 29a. Certifier  (Check only one)  1 ☐ Certifying Physic 2 ☐ Medical Examine  | cian: To the best of my know<br>er: On the basis of examinati<br>and manner stated.            | viedge, death<br>ion and/or inv | occurred at the tir<br>estigation, in my o | ne, date and place<br>pinion, death occur             | , and due to the ca<br>red at the time, da     | use(s) and mann<br>te and place, and  | er as stated.<br>due to the cause(s)   |
| To to   |   | Σ                | 29b. Signature and title of certifier  A · Frafficer   | · , HD   |                                 | 29c. License                               |   |  |                                       | Month, Day, Year)  |
| (2)02   |   | ;                | 30. Name and address of person who com Abdallah Kafrou   | npleted cause of death (Item   | 23a) (Type, P                   | ourt Ro                                    | ad, Ré  | andalls.                                       | town,                                 | HD 21133.  |

Registrar

MAY 1 4 2008

32. Registrar's Signature

MAY 1 4 2008

**Physician** /Medical Examiner

> and the burial-trar

attending physician

has

I or Attending Fafter death.

To the Hospital or within 24 hours af To the Funeral D

Director:

funeral director,

as

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Completed

Be

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Certification:

Medical

requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

**Funeral** 

Director

r 28a-f show notified at

"natural", or items 23a or

th and Mental Hygiene.
It is marked other than "nature traumatic event, the Medical.

permit. Pages 1 and 2 Department of Health s Important: If item 27 is any Injury or other tra

Directo

Funeral

þ

Completed

Be

and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical

IF FEMALE:

9 Unknown

4☐Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

23e. Did tobacco use contribute to the cause of death?

ng to death but not resulting in the underlying cause given in Part I.

24a. Was an

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Inknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed 2 No 26. Place of Death (Check only one)

25. Was case referred to medical 1 ☐ Yes 20 No 27. Manner of Death

1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 5 Pending investigation

3□ DOA 28b. Time of 28c. Injury at Work? Injury

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

1 Decertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number

29b. Signature and title of certifie

6 ☐ Could not be determined

D0051398

Other:

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Shero, M.D. 31. Date filed (Month, Day, Year) 25500 Point Lookout Road, Leonardtown, MD 20650

State Registra



08-03803

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| Daniel Portillo  |               | State of Maryland / Department of He 1-For State Registrar  State of Maryland / Department of He Certificate of De  |  |                         | 1. No. 200                            | 0 171.5   |
|--|---------------|---|--|-------------------------|---------------------------------------|---|
| Physici<br>Medical Exam  |               | 1. Decedent's Name (First, Middle,Last)  Daniel Echeverria Portillo   |  | Date of Death     Month | Day Year                              | 5. Time of Death<br>1838 hrs                    |
| سامان  |               | Daniel Echevellia Folcillo  | ty, Town, or Location of Death                                   | May 18, 20              | 4c. County of Deat                    |   |
|  |               |   | ver Spring   |                         | Montgomery                            |   |
| Funeral<br>Director  |               | none 1x M 2 F 32 Yrs.   | Under 1 Year If Under 24Hrs. Onths Days Hours Min.               | →                       | (MM/DD/YYYY) 9. Bir<br>Foreig<br>1976 | thplace (State or<br>PRI Salvador               |
| any  |               | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location   |  |                         |                                       | 10d. Inside City Limits                         |
| land<br>f show   | ō             | MD Montgomery Silver Spr  | ing  |                         |                                       | 1 X Yes 2 No                                    |
| the Mary a or 28a-   | Director      |   | Zip Code   | 100                     | g. Citizen of What Cou                | ntry?   |
| with the ms 23a c  | alD           |   | 20903<br>edent of Hispanic Origin? (Sp                           | ocify Voc or No         |                                       | Lvador<br>ican Indian, Black,                   |
| death v  | Funeral       |   | ecify Cuban, Mexican, Puerto                                     | Rican, etc.)            | White, etc.                           | ican ingian, black,                             |
| s after<br>ral", o   | by F          | 3 Widowed 4 Divorced If Yes, Give Year 1 X Yes  | 2 No specify:salv  |                         |                                       | nite  |
| 2 hour<br>"natu  | ted           |   | ual Occupation (Give kind of w<br>working life. DO NOT use retir |                         | 16b. Kind of Business/                | Industry  |
| 036<br>vithin 7<br>ene.<br>er than   | Completed     | 9th Pa  | inter  |                         | Painting C                            | ompany  |
| 21215-0036 uld be filed within 7: Mental Hygiene. marked other than c event, the Medical   |               | 17. Father's Name (First, Middle, Last)  Echeverria Serrano Antonio Serrano Echeverria  | 18.Mother's Name   | (First, Middle, Ma      | aiden Surname)                        |   |
| Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once. | To Be         |   | Zoila Poi  | rtillo d                | e Echeverr                            | ia<br>a. Zip Code)                              |
| MD d 2 shoulth and in 27 is aumatic  |               | Leonel Santos Echeverria 208 N Co   | ttage Road Ste   | erling,                 | Virginia 2                            | 0164  |
| Ore,<br>ges 1 an<br>of Hea<br>If ites  |               | 20a. Method of Disposition  1   |  | Date                    | 20c. Location - City or               | Town, State                                     |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite   | Н             | 4 Donation 5 Other Specify: Family Cem 21. Signature of Fungial Service Lice See 22. Name   | etery 05-2   | 29-08                   | El Salva                              | dor   |
| Ba<br>Perm<br>Depa<br>injur  |               | 11/5 //1 /5-00 103/1  | and Address of Facility $W.H.$                                   | . Bacon<br>Washing      | Funeral H<br>top DC 200               | ome, Inc.                                       |
| Physician  | CC.           | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mo failure. List only one cause on each line.                              | de of dying, such as cardiac or                                  | respiratory arres       | t, shock, or heart                    | Approximate Interval Between Onset and          |
| /Medical<br>Examiner   |               | Immediate Cause (Final disease or condition resulting in death)   |  |                         |                                       | Death   |
| N  | H             | or condition resulting in death)  Due to (or as a consequence of):  Cardiomegaly with left ventry.  | icular hypertrophy   | y.                      |                                       |   |
|  | iner          | if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of):   |  |                         |                                       |   |
| d<br>sit   | Examiner      | (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  |  |                         |                                       |   |
| execute<br>in and<br>I - tran  | calE          | d.  X UNPENDED  AMENDED  1 NE 200 6/2   | 17 per i   | nf ~993                 | 9-9-08 vt                             |   |
| . Box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit   | Medi          | X UNPENDED  AMENDED  TI line a-b, perME, g880 6/3, graduate program (see a construction)  IF FEMALE: 23c. If yes, outcome of pregnancy                              | 08 TT 17 Per 1   | III goos                | 23d. Date of deliver                  |   |
| Box 687  e death certific  the attending p   | ian/          | past 12 months?   |  | псу                     |                                       | Day Year  |
| Box<br>death<br>he atter<br>d for u  | Physician/    | 1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (S   | pecify)  |                         |                                       |   |
| P.O. s that the gned by t detache  | by Pt         | Part II. Other significant conditions contributing to death but not resulting in the underly  | ing cause given in Part I.                                       |                         | acco use contribute to                |   |
| , a .c. a  | ted t         |   |  | 1 Yes                   | 2 No 3 Prol                           |   |
| Records,<br>The law requir   | Completed     |   |  | autopsy<br>perform      | prior to                              | topsy findings available completion of cause of |
| . 4  |               | 25. Was case referred to medical  | 26.Place of Death (Check o                                       | 1 <b>✓</b> Yes 2        |                                       | es 2 No   |
| sis ysi  | o Be          | examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3   | Othor  |                         | esidence 6 Othe                       | r.  |
| _ <u>=</u>   | Ë.            | 27. Manner of Death  1 X Natural  28a. Date of Injury (Month, Day,Year)  28b. Time of Injury  |  | 28d. Describe ho        | w injury occurred                     |   |
| Sion   | ertification: | 2 Accident Investigation  | 1 Yes 2 No   | 20f Longton (Car        | not and Number of D                   | Douga North Co. Olfo                            |
| Divi   | ertif         | 3 Suicide 6 Could not be determined (Specify)   | ory, office banding, etc.  | or Town, Sta            |                                       | ral Route Number, City                          |
| Division  To the Hospital or Attend within 24 hours after death To the Foneral Director:   | Medical C     | 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at one) 2 Medical Examiner: On the basis of examination and/or investigation, in |  |                         |                                       |   |
| ()<br>E3E8   | Re            | and manner stated.  29b. Signature and title of certifier   | 29c. License number  |                         | 29d. Date signed (Mo                  | nth, Day, Year)                                 |
| Tie  |               | 30. Name and address of person who completed cause of death (Item 23a)  | O.C.M.E.   |                         | May 20, 2008                          |   |
| 0  |               |   | t, Baltimore, MD 21201   |                         |                                       |   |
| St<br>Regist   | ate<br>rar    | 31. Date filed Month, Day Year) MAY 2 3 2008  |  |                         |                                       |   |
| DHMH 17 Roy 1/20   |               |   |  |                         |                                       |   |

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Roberts May 2008 2:05 Barbara A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince Georges Southern Maryland Hospital Clinton 8. Date of Birth (Month, Day, Year) June 10, 1943 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 ☐ M 2 🔯 F 64 Washington, DC 159-36-6687 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at Clinton MD Prince Georges 1 ☑ Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 20736 USA 8905 Dangerfield Place Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23s Funeral . Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Government School Teacher Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James A. Roberts Sara V. Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2: Department of Health a Important: If Item 27 is any Injury or other trav Donald E. Roberts /Brother 6628 1st. St. NW, Washington, DC 20012 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glenwood Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 ☐Removal from State 05/20/2008 Washington, DC 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service License 716 Kennedy St. NW, Washington, DC 20011 23a. Part1. Enter the disease, or cod plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List any one false or each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Advanuel Liva Canun ank nowin /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 No 9☐Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performe certificate 1□ Yes 2⊠No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 🕱 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident **Director:** 6 Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 🗖 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Rout Rum M.D Da 3446 5.13.08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Georgia Are suit 3-32 silverspring MD 20902

State Registrar

RSINTAN FARAHIFAR MD 9801

32. Registrar's Signatur

31. Date filed (Month, Day, Year)

MAY 1 5 2008

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

| Amended  | it             | en For<br>Registrar#29c,per ph  | State of Mai   | yland / Dep<br>, <sub>BA</sub> <i>Ce</i>                                 | artment of H   |   | D Re  | eg. No.                              |  |
|--|----------------|---|--|--|--|---|---|--------------------------------------|--|
| Physi<br>/Med  |                | 1. Decedent's Name (First, Middle, Las.  JOSEPH RI  | YAN  |  |  |   | 2. Date of Deat<br>Month                        | Day Ye.                              | 3. Time of Death  1339 M                           |
| Exam   | iner           | 7 //  | ERAL F   | tosp.  | BERLI  | Location of Death                                     |   |                                      | ESTER  |
| Funera<br>Directo  |                | 5. Social Security Number 6. Se 493-09-8918 Usual Residence of Decedent   | X 7. Age (   | (In yrs. last birthday)  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        | 8. Date of Birth (Month, Day, 4-17-19           | Year) 9.                             | Birthplace (State or Foreign<br>Country)<br>DIANA  |
| e Maryland<br>Se-f ehow  | ctor           | 10a. State 10b. County DELAWARE SUSSEX  | 1  | Oc. City, Town or Lo   |  |   |   |                                      | 10d. Inside City Limits 1 ☐ Yes 2X No              |
| th with th<br>23a or 24<br>In Le no  | ai Director    | 10e. Street and Number 39755 FASSETT ROAL   | )  |  | 10f. Zip Code<br>19930   |   | 10  | 0g. Citizen of What<br>US            | Country?   |
| 1715-6036 within 72 hours after death with the Maryland ene. than "naturel", or iteme 23a or 28e-f ehow in Wedical Exameter minh be notified at  | by Funeral     | 11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced   | 12. Was Decedent Ev<br>Armed Forces?<br>1 X Yes 2 □ No<br>If Yes, Give<br>Year or Dates: 4 |  | Was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2🏋 No            | ispanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | pecify Yes or No-<br>Rican, etc.)               | 14. Race - A<br>Black, W<br>Specify: | merican Indian,<br>hite, etc.<br>WHITE             |
| 21215-0<br>d within 72 ho<br>piene.<br>r than "natur   | Completed      | 15. Decedent's Edi<br>(Specify only highest grad<br>Elementary/Secondary (0-12)   |  | (Give  | dent's Usual Occupa<br>kind of work done of<br>DO NOT use retired      | during most of world                                  | ring  | DEFENSE (                            | ss/industry  |
| yland yland yn yland yn yn yn yn yn yn yn yn yr yn yn yn yn yn yn yn yn yn yn yn yn yn   | To Be C        | 17. Father's Name (First, Middle, Last) FRANK A. RYAN   |  |  |  |   | e (First, Middle, M                             |                                      |  |
| Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel; or iteme 23a or 28e-1 ehow any injury or other traumatic event, the Medical Expiration must be notified as   |                | 19a. Informant's Name/Relationship (T)  JOHN H. RYAN/SON  20a. Method of Disposition  1 □ Burial ☑ (Cremetion 3 □ F)  |  | 6515<br>20b, Place of Dispo  | 75TH ST, string of material of the place                               | CABIN J   | OHN, MARY                                       |                                      | 818  |
| Baltimo<br>permit. Pag<br>Department<br>Important: I   | NIE STATE      | 4 Dogation 5 Other (Specify)  21. Signature of Funeral Service //Cens   |  |  | TATE OF STREET PLACE  CREMATORY  Name and Addres  LSON FUNE  ST AVENUE |   |   |                                      | DELAWARE   |
| barron, be executed to the buriar transit to buriar transit the buriar transit |                | 23a. Part1. Enter the dissipation of the process of condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. GI C  | e death. Do not ent  BLEFD consequence of):  BONE consequence of):  WWIA | er the mode of dying   | g, such as cardiac                                    | or respiratory arre                             | st,                                  | Approximate<br>Interval Between<br>Onset and Death |
| ath certif   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 3c. If yes, outcome of<br>1 ☐ Live birth 2 (<br>4 ☐ Pregnant at tim<br>9 ☐ Unknown         | Fetal death 3  | Ectopic pregnancy Other (specify)                                      |   |   | 23d. Date of o                       | delivery<br>Day Year                               |
| wrequires that the deben signed by the should be detached  | Š              | Part II. Other significant conditions con   | ntributing to death but r  | not resulting in the u   | nderlying cause give   | n in Part I.  | 1 □ Yes   | s 2× No 3□                           | to the cause of death?  Probably 4 □Unknown        |
|  | e Completed    | 25. Was case referred to medical  |  |  |  |   |   | prior t<br>ed? death<br>No 1 □ Y     |  |
| ding Phys<br>After this<br>funeral di  | ation; To B    | examiner?   | 1 Anpatient<br>28a. Date of Injury<br>(Month, Day Y  | 2 ER/Outpation<br>28b. Time of<br>Injury                                 | 28c. Injury<br>Work  | r: 4 🗌 Nursing Ho                                     | h Check only one me 5 Resider 28d. Describe how | nce 6 Other (S)                      | pecify)  |
| : 2 g g c  | Certification; | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined   | 28e. Place of Injury<br>building, etc. (   | Specify)   |  |   | City or Town,                                   | State)                               | Rural Route Number,                                |
| To the Hospitel within 24 hours of To the Funeral of   | Medical        | 29a. Certifier (Circle only) 2 Medical Examinations)  29b. Signature and title of certifier   | sician: To the best of n<br>ler. On the basis of ex<br>and manner stated                   | amination and/or inv   | estigation, in my op   | inion, death occur                                    | red at the time, dat                            | te and place, and d                  | ue to the cause(s)                                 |
| E WE   |                | IThen,  | M)   | h /Itom 22-1 (**   | 29c. License D00599  |   |   | d. Date signed (Mo                   |  |
| BAINT  | ate            | 30. Name and address of person who co THURN DANC 31. Date filed (Month, Day, Year)  | OE. Higgiotian o   | ROAD 5   |  | E201 B  | PERLIN,   | m) 2                                 | 1811   |
| Regis  | trar           | MAY 1 5 200   | 18 Acres   | . K de   | and I  |   |   |                                      |  |

DHMH 17 Rev 1/2001

DOB! 4/17/14 DOD: 5/14/108 TOD: 13:39

Ayon, Joseph 55# 493-09-8918

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month nargare 50 M 0 /Medical acility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kel Sal 4 MD Ni sbur Wicomuco 5. Social Security Number If Under 24 Hrs... 6. Sex Z-Age (In yrs. last birthday) Funeral Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 1 M 2 F Months Davs Hours Min. 221-56-7284 Director Pennsylvania Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits the Madical Examiner count by notified at Director 1 X Yes 2 ☐ No MD Sussex Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 105 Times Square Itеms 23a 21801 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No ģ Specify White Specify: 3 XWidowed 4 ☐ Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) å Merle Hess ည Millie Roney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itsm 27 Is rr any injury or other traurr once. 28342 Discountland Road Laurel, De. 19956
Date 20c. Location · City or Town, State Kay Murphy (Friend) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Cem. May 14,2008 Easton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 700 West Street Hannigan, Short, Disharoon F. H.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heak dailure. List only one cause on each line. Hannigan, Short, Disharoon F.H. Laurel, Del. 19956 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner CLOSTRIDUM DIFFICILE Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of). The law requires that the death certificate be executed burial-transit THRIVE Mura To resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, physicien Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal de 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy ŏ 2 Fetal death Month 4 Pregnant at time of death Day Year signed by the at the detached for 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 **N**O 1 🗌 Yes 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed: certificate 2 No 1 ☐ Yes 2 ☐ No Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place Death Check only one Hospital: 1 Inpatient Other: Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this To the Funeral Director: After the completely filled in by the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 2 Accident investigation М 1 Tes 2 No 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D63433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUTORD ST. # 504B, SAUSBURY MD 21804 POSMI 106 31. Date filed (Month, Day, egistrar's Signature State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** *5*409 05 08 08 White Ruark Estelle Marie /Medical County of Death Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Regional Medical Salisbury Wicomia Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Min. 1 □ M 2X F Months Days Hours 218-20-5655 Director 7-2-1926 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Director Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1718 Crestwood Circle 21804 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ White Levi Ida Estelle Shockley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger Ruark - Husband 1718 Crestwood Circle, Salisbury, Maryland 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Siloam Cemetery 5-13-2008 | Siloam, Maryland 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Funeral Service Licensee 705 E. Main Street, Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List out one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner STIOKE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Yahours after death.

Funeral Director: After this certificate has been signed by the attending physician and eastly filled in by the funeral director, page 2 should be detached for use as the burnal-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was a... autopsy performed? Yes 2 No 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 27 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of contine 29c. License number 29d. Date signed (Monthy Day, Year) )55658 30. Name and address of person who mpleted cause of death (Item 23a) (Type, Print) Salisbury MD 21801 arroll 20 State 1 2 2008 Registrar

|                     |   |                | 1- For State of Maryland / Department  | artment of Health and Menta<br>rtificate of Death   | Hygiene<br>Reg. No. 2008 17457   |
|---------------------|---|----------------|--|---|--|
| ۲                   | Physici   |                | 1. Decedent's Name (First, Middle, Last) Shirley Elaine Rill   | Mor   |  |
|                     | /Medic  |                | 4a. Facility Name (If not institution, give street and number)   | 4b. City, Town, or Location of Death  | 12 2008 1:30 a. <sup>M</sup> 4c. County of Death   |
|                     |   |                | 14909 Old Hanover Road   | Upperco   | Baltimore  |
| le i                | Funeral<br>Director   |                | 5. Social Security Number  216-44-0157  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 64 Yrs.  | Months Days Hours Min. (Mon   | e of Birth nth, Day, Year)  9. Birthplace (State or Foreign Country)  MD                                 |
|                     | land land   |                | Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo   | ocation   | 10d. Inside City Limits  |
|                     | Mary<br>Ff sho<br>fied a  | tor            | MD. Baltimore Upperco  |   | 1 ∐Yes 2X No   |
|                     | th the<br>or 28a<br>e noti  | Director       | 10e. Street and Number   | 10f. Zip Code   | 10g. Citizen of What Country?  |
|                     | s 23a   | rall           | 14909 Old Hanover Road   | 21155   | USA  |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. | by Funeral     | 1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ No   | Was Decedent of Hispanic Origin? (Specify Yes<br>If Yes, specify Cuban, Mexican, Puerto Rican, e<br>1 □ Yes | s or No- 14. Race - American Indian, Black, White, etc.  Specify: white                                  |
| 9                   | 2 hou<br>natura<br>ical E   | ted            | 15. Decedent's Education 16a. Deced  | dent's Usual Occupation   | 16b. Kind of Business/Industry   |
| 2                   | ithin 7<br>ne.<br>nan "n  | Completed      | (Specify only highest grade completed) (Give life. L   | kind of work done during most of working<br>DO NOT use retired)   |  |
| 2                   | Hygier<br>Hygier<br>ther th   |                | 12 h   | air stylist 18. Mother's Name (First, I   | beauty salon   |
| Maryland 21215-0036 | ld be fental I  | To Be          | William Carlos Rhoten, Sr.   | Rosena Edna   | ,  |
| ary                 | shou<br>and M<br>s mar  | F              |  | ng Address (Street and Number or Rural Route  |  |
| Σ,                  | and 2<br>ealth a<br>n 27 i  |                |  | Old Hanover Rd., Upp  | erco, Md. 21155  |
| altimore,           | ges 1<br>It of H<br>If Iter<br>or oth   |                | 20a. Method of Disposition  1X Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposemetery, crem                                  | sition (Name of Date matory or other place)   | 20c. Location - City or Town, State  |
| E E                 | iit. Pa<br>Irtmen<br>Irtant:<br>Injury  |                |  | UMC Cemetery 5/15/2 Name and Address of Facility Flin   |  |
| Ba                  | perm<br>Depa<br>Impo<br>any i   |                | 1 2 2  | 34 S. Main Street, Ha   | e Funeral Home<br>mostead, Md. 21074   |
|                     |   |                | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. |   |  |
| Ŋ.                  | Physician   |                | Immediate Cause (Final   | Inforention   | Onset and Death  |
| A.                  | /Medical<br>Examiner  |                | disease or condition resulting in death)  a. Due tr (or as a consequence of):  | 14.000.00   |  |
| -                   | W. Jane   | -              | Sequentially list conditions, b. Due to or a la consequence of):   | AUD   |  |
|                     | uted<br>d<br>ansit  | Examiner       | Sequentially list conditions, it styles to lor and a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events   | nelliter  |  |
| Ď,                  | e exection and an and an and an and an and an and an and an and and   |                | resulting in death) Last  Due to (or as a consequence of):   |   |  |
| 09/8                | requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit   | dical          | d  |   |  |
| ×                   | leath certific<br>attending p   | Physician/Med  | IF FEMALE: 23b. Was decodent program 23c. If yes, outcome pf pregnancy   |   | 00181111   |
| ROX<br>POX          | death<br>atter  | iciar          | in the past 12 months?  1 Vee 2 In the past 12 months?  4 Pregnant at time of death 5  | Ectopic pregnancy Other (specify)   | 23d. Date of delivery  Month Day Year  |
| J<br>O              | at the<br>by the<br>tache   | hys            | 9☐Unknown  |   |  |
| s,                  | w requires that the de<br>been signed by the<br>should be detached  | by F           | Part II. Other significant conditions contributing to death but not resulting in the un  | nderlying cause given in Part I. 23e  | e. Did tobacco use contribute to the cause of death?   |
| ecord               | requi   | sted           | Mondaid obserty  |   | 1 Yes 2 No 3 Probably 4 Onknown  |
| 9                   | The law<br>ite has b  | Completed      |  | 24a   | a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? |
| N I I a             | sician: The law<br>certificate has l<br>irector, page 2 s   | င္ပ            | 25. Was case referred to medical   |   | Yes 2 → No 1 □ Yes 2 □ No  |
| <u> </u>            | ysicia<br>is ceri<br>direct   | O D            | examiner?  1   Yes   Hospital: 1   Inpatient 2   ER/Outpatient   | 26. Place of Death Check  | ☐ Hesidence 6 ☐ Other (Specify)  |
| 0                   | ng Ph<br>fter th  | L:iic          | 27. Manner of Death  → Natural 5 Pending (Month, Day Year) Injury  128b. Time of (Month, Day Year)   |   | scribe how injury occurred   |
| SIO                 | tendi<br>leath.<br>tor: A<br>the fu   | catic          | 2 Accident investigation   | M 1 Yes 2 No  |  |
| UIVISION            | or At<br>after d<br>Direc<br>in by  | Certification: | 4 Homicide determined 28e. Place of injury - At home, farm, street building, etc. (Specify)  |   | ation (Street and Number or Rural Route Number,<br>or Town, State)                                       |
|                     | spital<br>nours<br>neral<br>/ filled  |                | 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death   | n occurred at the time, date and place, and due   | to the cause(s) and manner as stated.  |
|                     | To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,  | edical         | (Check only 2  Medical Examiner: On the basis of examination and/or invoine) and manner stated.  | vestigation, in my opinion, death occurred at the   | e time, date and place, and due to the cause(s)  |
|                     | To To To To To To To To To To To To To T  | Σ              | 29b. Signature and title of certifier  | 29c. License number   | 29d. Date signed (Month, Day, Year)  |
|                     | WIL   |                | maris m. Iteragen  | wo 1712102  | 2/15/08  |
|                     | 6   | Į              | 30. Name and address of person who completed cause of death (Item 23a) (Type, F  | Uho 417 mila  | 29d. Date signed (Month, Day, Year)  5/12/08  MDGh & West Mons due  (MANY TOTAL)                         |
|                     | Sta   | ie             | 31. Date filed (Month, Day, Year) 32. Registrar's Signature  | - I I CANALINA  | man Sas o  |
|                     | Registra  | ar             | MAY 1 3 2008 Server & 4  | Locale  | 11.2.2   |

| Physician   Josephine   P.   Ryan   Moorth   May 18, 2008   9:15   Earniner   Formation    |                  |
|--|------------------|
| As   City   Towns or Locations of Death   As   City   Towns or Locations of Death   As   City   Towns or Locations of Death   As   City   Towns or Locations of Death   As   City   Towns or Locations of Death   As   City   Towns or Locations of Death   As   City   Towns or Locations of Death   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns or Locations   As   City   Towns   As   City   Towns   As   City   Towns   As   City   Towns   City     | of Death         |
| Civista Medical Center   | 5_a <sup>M</sup> |
| Social    |                  |
| Director    Director   Director   Display   Director   Display   D |                  |
| 102. Inside   103. State   105. County   105. City, Town or Location   103. Inside   107. The property of th   |                  |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   | City Limits      |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   | es 2/1 No        |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   |                  |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   |                  |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   |                  |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   |                  |
| Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   Own Home      18. Mother's Name (First, Middle, Maidan Surname)   |                  |
| Physician Medical Examiner  Physician Factorial Factoria |                  |
| Physician Medical Examiner  Physician Factorial Factoria |                  |
| Physician Medical Examiner  Physician Factorial Factoria |                  |
| 20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Location - City or Town   20c. Location - City or Town   20c. Location - City or Town   20c. Location - City or Tow |                  |
| 20a. Method of Disposition   20b. Place of Disposition (Name of cemetery, crematory or other place)   20c. Location - City or Town, State   20c. Location - City or Town   20c. Location - City or Town   20c. Location - City or Town   20c. Location - City or Tow |                  |
| 1 Start   2   Gremation   3   Removal from State   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   4   Donation   5   Other (Specify)   St. Ignatius Cemetery   5/22/2008   Port Tobacco, MD   Port Toba   |                  |
| Physician /Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Congestive Heart Failure  25a. Due to (or as a consequence of):  25b. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25d. Due to (or as a consequence of):   |                  |
| Physician /Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Examiner  25a. Congestive Heart Failure  25a. Due to (or as a consequence of):  25b. Due to (or as a consequence of):  25c. Due to (or as a consequence of):  25d. Due to (or as a consequence of):   |                  |
| Physician /Medical Examiner  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Sequentially list conditions, if any, leading to immediate cause. (Final death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underphing Cause (Disease or injury that imitated events resulting in death) Last  FFEMALE:  23d. Date of delivery  Month  Day  Pregnant at time of death  Significant conditions contributions contributions to death but not coulding in the underthing cause given in Real L.  23d. Date of delivery  Month  Day  Pregnant at time of death  Significant conditions contributions contributions to death but not coulding in the underthing cause given in Real L.  23d. Date of delivery  Month  Day  Pregnant at time of death  Significant conditions contributions contributions to death but not coulding in the underthing cause given in Real L.  23d. Date of delivery  Month  Day  Pregnant at time of death  Significant conditions contributions contributions to death but not coulding in the underthing cause given in Real L.  23d. Date of delivery  Month  Day  Pregnant at time of death  Significant conditions contributions contributions contributions to death but not coulding in the underthing cause given in Real L.  23d. Date of delivery  Month  Day  Pregnant at time of death  Significant conditions contributions contributions to death but not could in the cause of the death |                  |
| Physician /Medical Examiner  Needical Scale Indexed to constitute a constitution in the of death but not resulting in the underlying examiner in Examiner  Needical E | etween           |
| Due to (or as a consequence of):    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Due to (or as a consequence of):   | d Death          |
| Sequentially list conditions, if any, leading to immediate cause. Enter truns right and that initiated events resulting in death) Last  Sequentially list conditions, if any, leading to immediate cause. Enter truns right at initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  Due to ( |                  |
| C. Due to (or as a consequence of):    Comparison of the part of t |                  |
| C. Due to (or as a consequence of):    Comparison of the part of t |                  |
| O T THE STANDARD STAN |                  |
| IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2xC No 9   Unknown   1   Yes   2xC No 9   Unknown   23c. If yes, outcome pf pregnancy   23d. Date of delivery   Month   Day   Month   Month   Day   Month   Month   Day   Month   Day   Month   Mon   |                  |
| We see the part of the part 12 months?  O a state of the part 12 months?   |                  |
| So of the state of the contribution of the con | V                |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    23e. Did tobacco use contribute to the cause of the  | Year             |
| 1   Yes 2   No 3   Probably 4    24a. Was an autopsy prior to completion of autopsy prior to  | f death?         |
| 24a. Was an autopsy finding prior to completion of   |                  |
| O d g g l c autopsy autopsy autopsy c prior to completion o  |                  |
| <u> </u>   |                  |
| 24a. Was an autopsy performed?    Yes   2 No   25. Was case referred to medical examiner?   1 Yes   2 No   25. Was case referred to medical examiner?   1 Yes   2 No   25. Was case referred to medical examiner?   1 Yes   2 No   25. Was case referred to medical examiner?   1 Yes   2 No   25. Was case referred to medical examiner?   1 Yes   2 No   25. Was case referred to medical examiner?  |                  |
| examiner?  1   Yes   2   No   Hospital:   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specify)  |                  |
| 27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred   |                  |
| O D G G D Suicide 1 Suicide 6 Could not be 28e Place of injury. At home farm street factors office   |                  |
| Second Completion of death   Second Completion of Death   Second Complet   | mber,            |
| 29a. Certifier (Check only and local Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |                  |
| The state of the s | (s)              |
| and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year   |                  |
| 29c. License number D-0056949  29d. Date signed (Month, Day, Year) 5/22/08   |                  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)   |                  |
| Kamakshi Baig, MD 6620 Crain Hwy, LaPlata, MD 20646  |                  |
| State Registrar 31. Date filed (Month, Day, Year) 32. Figistrar's Signature 32. Figistrar's Signature  |                  |

Records, P.O. Box 68760, Division or Vital To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by

> State Registrar

29b. Signature and title of ce

s of

30. Name and address

C 31. Date filed (Month, Day, Year) Registrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

**ORIGINAL** 

29c. License number

29d. Date signed (Month, Day, Year)

|  |   | 1 - For<br>State<br>Registrar   |  | State of   | Marylan  |  | rtificate of   | lealth and<br><i>Death</i>   | i Mental H   | ygien<br>Reg. N   | Z 13 11 2  | 3 174   |
|--|---|---|--|--|--|--|--|--|--|---|--|---|
| Physicia   |   | 1. Decedent's Na  | me (First, Middle, La:   | st)  | H  |  |  |  | 2. Date of D<br>Month<br>May                                     | Death D   | Day Year 2008  | 3. Time of Dec  |
| /Medica<br>Examine   |   |   | (If not institution, give  | e street and num   | nber)  |  | 4b. City, Town, o  | or Location of De  |  |   | tc. County of De   |   |
|  |   | 8308 E  | Bonair Ro  | oad  |  |  | Parkv  | ille   |  |   | Baltim   | ore   |
| Funeral<br>Director  |   | 5. Social Security 210-26-  | -9953 <sup>1</sup>   | ex<br>ŽM 2□F   | 7. Age (In yrs.<br>78  | last birthday)<br>Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hi<br>Hours Mi   |  | lirth<br>Day, Yea<br>L5,  | 1930 <sup>9. Bi</sup>  | inthplace (State or Fo<br>Country)<br>PA  |
| and *  |   | Usual Residence<br>10a, State   | of Decedent  10b. County   |  | 10c. Cit   | y, Town or Lo  | cation   |  |  |   |  | 10d. Inside City L  |
| within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-i ehow ite Madical Examina must be notified at  | ō   | MD  | Baltim   | nore   | 100.01   |  | rkville  |  |  |   |  | 1 Yes 2   |
| 28a-   | rect  | 10e. Street and N   | lumber   |  |  |  | 10f. Zip Code  |  |  | 10a. C  | Citizen of What C  | Country?  |
| 23a or   | I D   | 8308  | Bonair F   | Road   |  |  | 212  | 34   |  |   | .S.A.  | ,   |
| ems dear   | Funeral Director  | 11. Marital Status  |  | 12. Was Deced  | dent Ever in U.  | .S. 13.  | Was Decedent of H<br>f Yes, specify Cuba   | dispanic Origin?   | (Specify Yes or N  | 0-  | 14. Race - Am  |   |
| Examen   | ρ   |   | urried 2 Married 4 Divorced  | 1 Yes<br>If Yes, Give<br>Year or Da  | Korea<br>Korea<br>tes: War   | n i  | 1 ☐ Yes 2 XNo  |  | orto mean, etc./   |   | Black, Wh  | White   |
| dinal.   | etec  | (Sp   | 15. Decedent's Ed<br>ecify only highest gra  | fucation<br>de completed)  |  | 16a. Deced   | lent's Usual Occup<br>kind of work done<br>OO NOT use retired  | ation<br>during most of w  | orking   | 16b.  | Kind of Busines  | s/Industry  |
| than   | Completed   | Elementary/Sec  |  | College (1-  | 4or 5+)  | _  | <i>00 NOT use retire</i> c<br>ntenance   |  |  |   | Hospit   | 21  |
| other than   | ပ္ပ   |   | 2<br>e (First, Middle, Last)   |  |  | Mali   | rcenance   |  | ame (First, Middl  |   |  | aı  |
| 0 0 C  | To Be   |   | C. Roth  |  |  |  |  |  | Le V. R  |   | ,  |   |
| mari   | ř   |   | Name/Relationship (7   |  |  | 19b. Mailir  | g Address (Street  |  |  |   |  | Zip Code)   |
| em 27 le   | 19  | Kathy Ga  | iski/Daug  | hter   |  |  | Bonair   |  |  |   |  |   |
| or other   |   |   | 2 ☐ Cremation 3 🖾  |  | tate Wo  | odiawi   | sition (Name of<br>naton or other place<br>1 Memor   | ral May  | 7 24,  |   | Location - City o  |   |
| Department of near Important: If item 2 any injury or other 2005e.   | i   | 21. Signal  | 5 ☐ Other (Specify<br>era Service Licen  |  | CL.  |  |  | ss of FacilityJ.   |  | enst  |  | tuary, In   |
| 2 4 0  |   | On Part San   | mes A.   | Nant   |  |  | Second   |  |  |   | PA 1734  |   |
|  | ŀ   | snock, or ne  | the disease, or comp<br>eart failure. List only  | one cause on ea  | ch line.   | n. Do not ente   | er the mode of dyin  | ng, such as cardi  | ac or respiratory  | arrest,   |  | Approximate<br>Interval Betwee<br>Onset and Dea   |
| sician<br>edical   |   | Immediate Cause<br>disease or condit<br>resulting in death  | ion  |  | onqe   |  | e hea  | nt to  | culuv.   | <u>e</u>  |  |   |
| aminer   |   |   |  | Due to (c  | or as a comsequ  |  |  | - 1  |  |   |  |   |
| 953m2  | Jer   | Sequentially list of any, leading to cause. Enter Und Cause (Disease of   | conditions,<br>immediate   | b. Due to (o   | r as a consequ   | S I VI   | 43   | syna   | VONU   | 2   |  |   |
| ransit   | Examiner  | that initiated even   | IS III   | · a  | trua   | I.   | Fibri  | (1 octs  | M-   |   |  |   |
| hysician and the burial-transit  | ×   | resulting in death)   | ) Last   | Due to (o  | r as a consequ   | uence of):   |  | V V  |  |   |  |   |
|  | _   |   |  | d  |  |  |  |  |  |   |  |   |
| the b  | ca  |   | •  | u  |  |  |  |  |  |   |  |   |
| ding physic  | ca  | IF FEMALE:  | •  | 23c. If ves. outc  | ome of pregna  | ncv  |  |  |  |   | 004 D-1  |   |
| or use as  | ca  | 23b. Was decede<br>in the past 1:   | 2 months?  |  | ome of pregna th 2 Fetal nt at time of de  | death 3  | Ectopic pregnancy  | ,  |  |   | 23d. Date of de<br>Month   | olivery Day Year  |
| or use as  | ca  | 23b. Was decede   | 2 months?  | 1 Live bir   | th 2 ☐ Fetal<br>nt at time of de   | death 3  |  | ,  |  |   |  | ,   |
| uttending p<br>or use as   | Physician/Medical   | 23b. Was decede<br>in the past 1.<br>1 Yes 2<br>9 Unknow  | 2 months?  | 1 ☐ Live bir<br>4 ☐ Pregna<br>9 ☐ Unknov   | th 2 ☐ Fetal<br>nt at time of de<br>wn   | death 3 = sath 5 =   | Other (specify)  |  | 23e. Did   | tobacco   | Month  | ,   |
| igned by the attending p be detached for use as  | by Physician/Medical  | 23b. Was decede<br>in the past 1.<br>1 Yes 2<br>9 Unknow  | 2 months?  | 1 ☐ Live bir<br>4 ☐ Pregna<br>9 ☐ Unknov   | th 2 ☐ Fetal<br>nt at time of de<br>wn   | death 3 = sath 5 =   | Other (specify)  |  |  | tobacco<br>Yes 2  | Month use contribute t   | Day Yea   |
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| should be detached for use as  | by Physician/Medical  | 23b. Was decede<br>in the past 1.<br>1 Yes 2<br>9 Unknow  | 2 months?  | 1 ☐ Live bir<br>4 ☐ Pregna<br>9 ☐ Unknov   | th 2 ☐ Fetal<br>nt at time of de<br>wn   | death 3 = sath 5 =   | Other (specify)  |  | 24a. Wa:   | Yes 2<br>s an<br>opsy<br>ormed?   | Month  use contribute to the c | Day Yea  to the cause of deat  robably 4 Aunk  utopsy findings ava completion of caus   |
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| After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as funeral director, page 2 should be detached for use as funerated by Dhistological for the formulation by Dhistological for the formulation of the f | To Be Completed by Physician/Medical                        | 23b. Was decede in the past 1: 1   Yes   2 9   Unknow  Part II. Other sign  Children  25. Was case referexaminer? 1   Yes   2 27. Manner of Das   | arred to medical  No ath  5 Pending investigation  6 Could not be  | 1 Live bir 4 Pregna 9 Unknov ontributing to dea  | th 2 Fetal nt at time of de wn at time of de wn at time of de wn at the but not result to the but not result t | death 3 = sath 5 = sa | other (specify)  Identifying cause give  A V A V  S A DDA  28c. Injun Worl  M 1  | en in Part I.  26. Place of Deer: 4 \( \text{Nursing} \)   | 24a. Wa auto perf 1 yes eath (Check only Home 5 es 28d. Describe | s an ppsy ormed? 2 1 N one) idence how inju   | Month  use contribute to the c | Day Yea   |
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| After this certificate has been signed by the attending p funeral director, page 2 should be detached for use as   | Medical Certification: To Be Completed by Physician/Medical | 23b. Was deceden the past 1: 1   Yes 2 9   Unknow Part II. Other sign  25. Was case reference warminer? 1   Yes 2 27. Manner of Deat 1   Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifier (Check only one)  29b. Signature and                   | arred to medical  No ath  Could not be determined  Could not be determined  Could not be determined  title of certifier  Cress of person who could not be determined | Hospital:  28e. Place of building:  28d. Date of (Month)  28d. Date of on the base and manner.                       | th 2 Fetal nt at time of de wn  ath but not resurce to the control of the control of the control of Injury - At hog, etc. (Specify best of my known is of examinat or stated.  | death 3 and sath 5 and sath 5 and sath 5 and sath 5 and sath sath sath sath sath sath sath sath  | other (specify)  Identifying cause give  A V A V  3 DDA Dth  28c, Injun Work M 1 1  eet, factory, office  occurred at the tirr estigation, in my of  | 26. Place of Deer: 4 \( \triangle \) Nursing yat (?)  Yes 2 \( \triangle \) No one, date and place binion, death occ | 24a. Wa auto perf 1 yes eath (Check only Home \$28d. Describe    | s an opsy ormed? 250 None) cidence how injute (Street a bwn, State a cause(s, date an | Month  use contribute t  2 No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Speury occurred   | Day Yea  To the cause of deat  Trobably 4 AUNK  Utopsy findings ava completion of caus  S 2 No  Pural Route Number,  s stated. e to the cause(s)          |
| within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending porting to the funeral director, page 2 should be detached for use as Madical Certification. To be Completed by Directors.  | Medical Certification: To Be Completed by Physician/Medical | 23b. Was deceden the past 1: 1   Yes 2 9   Unknow Part II. Other sign  25. Was case reference awaminer? 1   Yes 2   27. Manner of Dea 1   Natural 2   Accident 3   Suicide 4   Homicide  29a. Certifler (Check only one)  29b. Signature and 30. Name and 30. | arred to medical  No ath  Could not be determined  Could not be determined  Could not be determined  title of certifier  Cress of person who could not be determined | Hospital:  28e. Place of building:  28d. Date of (Month)  28d. Date of on the base and manner.                       | th 2 Fetal nt at time of de wn  ath but not resure the function of the functio | death 3 and sath 5 and sath 5 and sath 5 and sath 5 and sath sath sath sath sath sath sath sath  | other (specify)  Identifying cause give  A V A V  3 DDA Dth  28c, Injun Work M 1 1  eet, factory, office  occurred at the tirr estigation, in my of  | 26. Place of Deer: 4 \( \triangle \) Nursing yat (?)  Yes 2 \( \triangle \) No one, date and place binion, death occ | 24a. Wa auto perf 1 yes eath (Check only Home \$28d. Describe    | s an opsy ormed? 250 None) cidence how injute (Street a bwn, State a cause(s, date an | Month  use contribute t  2 No 3 P  24b. Were a prior to death? 1 Yes  6 Other (Speury occurred   | Day Yes  to the cause of dea  trobably 4 Duni utopsy findings avi completion of caus  s 2 No  acify)  ural Route Number  s stated. e to the cause(s)      |

|  | _         | For<br>State<br>Registrar   |   | e of Maryl   |                                       |  | t of Hea<br>e of De                  |   | /lental Hy   | -                             | <b>20</b> 08  | 1761   |
|--|-----------|---|---|--|---------------------------------------|--|--------------------------------------|---|--|-------------------------------|---|--|
| Physicia   | _         | Decedent's Name (First, Mi  Thomas  |   | 1.   |                                       |  |                                      |   | 2. Date of D<br>Month<br>05                          |                               | 2 <sup>Year</sup> 2008                              | 3. Time of Deat                                      |
| /Medica  |           |   |   |  |                                       |  | 4b. City, Town, or Location of Death |   |  |                               | County of Death                                     | J.4J I   |
|  |           | Clinton Nurs  | ing, LLC                                    | ng, LLC  |                                       |  | inton                                |   |  | Pr                            | ince Geo  | orges  |
| uneral<br>irector  |           | 5. Social Security Number 578-60-1536   | 6. Sex<br>1 <b>X</b> M 2 □                  |  | yrs. last birthday,<br>Yrs.           | If Under<br>Months                     |                                      | Under 24 Hrs.<br>lours Min.                   | 8. Date of Bi<br>(Month, D<br>2/29/                  | rth<br>ay, Year)<br>1 Q / Q   | Cou   | olace (State or Fore<br>ntry)<br>ginia               |
| -  | Ì         | Usual Residence of Decedent<br>10a. State 10b. Cou  | ntv   |  | . City, Town or L                     | ocation                                |                                      |   | 2/2/   | 1740                          |   | 10d. Inside City Lim                                 |
| a-f sho<br>ified at  | ior       | DC  | ,   |  | Washing                               |  |                                      |   |  |                               |   | 1 □Yes 2/  |
| or 28;<br>pe not   | Director  | 10e. Street and Number  |   |  |                                       | 10f. Zip                               | Code                                 |   | -  | 10g. Citiz                    | en of What Cou                                      | ntry?  |
| s 23a<br>nust I  | <u>ra</u> | 602 Columbia  |   |  |                                       |  | 0001                                 |   |  | US                            |   |  |
| xan  | by Fur    | 11. Marital Status  1 XNever Married 2 N 3 Widowed 4 Divorce  | arried Arm                                  | Decedent Ever i<br>ed Forces?<br>Yes 2[X]No<br>es, Give<br>r or Dates: | 1                                     | Was Deced<br>If Yes, spec<br>1 ☐ Yes 2 |                                      | nic Origin? (Sp<br>lexican, Puerto<br>pecify: | ecify Yes or No<br>Rican, etc.)                      |                               | 4. Race - Americ<br>Black, White,<br>Specify: Black | etc.   |
| dical  | eted      | 15. Dece<br>(Specify only hig   | lent's Education<br>hest grade comple       | eted)  | 16a. Dece                             | dent's Usua                            | al Occupation                        | n<br>ng most of work                          | rina   | 16b. Kin                      | d of Business/In                                    | dustry   |
| than<br>be Me  | Completed | Elementary/Secondary (0-1: 9th  |   | ege (1-4or 5+)   |                                       |  |                                      | perator                                       |  | Guy                           | H. Lewi   | s and Son<br>Inc.                                    |
| e 5  | Be C      | 17. Father's Name (First, Midd  | lle, Last)                                  |  |                                       |  | 1                                    | Mother's Nam                                  |  | e, Maiden S                   | Surname)  |  |
| ls marked raumatic ev  | To B      | William O. Sm   |   |  |                                       |  |                                      | essie (                                       |  |                               |   |  |
| If item 27 Is marke<br>or other traumatic  |           | 19a. Informant's Name/Relation  Jesse Smith/E   |   | 1)   | 1                                     |  | (Street and )                        |   | $rac{1}{2}$ Route Numl                              |                               | Town, State, Zip 20002                              | Code)  |
| r other  | 1         | 20a. Method of Disposition  |   | 20   | b. Place of Dispo<br>cemetery, cre    |  |                                      |   | Date Date  |                               | cation - City or To                                 | own, State   |
| ant; If<br>ury or  |           | 1 🖾 Burial 2 □ Cremation 4 □ Donation 5 □ Other   |   | nom state  | faryland                              |  |                                      | 5/16/   | /2008  | Laur                          | el, Mar   | yland  |
| Important; If item 27<br>any Injury or other tr<br>once.   |           | 21. Signature of Funeral Serv   | ce Licensee Maul                            | hall   | 4                                     |  |                                      |   |  |                               | neral Ho  |  |
| sician and the purial-transit the burial-transit th | Cal EX    | Immediate Cause (Final disease or condition resulting in death)  Secure ntiotive list notice if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  List only one cause on each line.  PESP (Au TA, lure  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of): |   |  |                                       |  |                                      |   |  |                               | Approximate Interval Between Onset and Death        |  |
| ed by the attending physician and detached for use as the burial-transit   |           | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown   | 1 □ l<br>4 □ l                              | s, outcome pf pre<br>Live birth 2 ☐ F<br>Pregnant at time<br>Unknown   | Fetal death 3                         | ⊒Ectopic pre<br>⊒ Other (spe           |                                      |   |  | 23                            | 3d. Date of delive                                  | ery<br>Day Year                                      |
| s been signed be seta  |           | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |                                       |  |                                      |   | 23e. Did tobacco use contribute to the cause of deat |                               |   | ,  |
| should   | ne e      | - Ca  | W To  |  | •                                     |  | 1[                                   |   |  | Yes 2 No 3 Probably 4 Unknown |   |  |
|  |           | 25. Was case referred to med  |   |  |                                       |  |                                      |   | 24a. Was<br>auto<br>perf<br>1□ Yes                   |                               | prior to co<br>death?                               | ppsy findings availa<br>mpletion of cause of<br>2 No |
| this certification all director  |           | examiner?   | Hoenital                                    | 1 ☐ Inpatient 2  | 2 □ ER/Outnatier                      | nt 3□ DO/                              | 011                                  | Place of Deat                                 |  |                               | []O. (0. )  |  |
| After  | 1000      | 27. Manner of Death 1 ☑ Natural 5 ☐ Pen 2 ☐ Accident inve   | 28a. I                                      | Date of Injury<br>(Month, Day Year                                     | 28b. Time o                           |  | 8c. Injury at<br>Work?               |   | 28d. Describe  |                               | Other (Special                                      | (y)  |
| To the Funeral Director: After completely filled in by the funeral Medical Certification.  | Silling.  | 3 Suicide 4 Homicide 6 Could not be determined 6 Could not be determined 6 Could not be determined 6 Could not be determined 6 Could not be determined 6 Could not be determined 6 City or Town, Street and Number or Rural Route Notice building, etc. (Specify)   |   |  |                                       |  |                                      |   | al Route Number,                                     |                               |   |  |
| o the Funer<br>ompletely fill  |           | 29a. Certifier 1 Certif<br>(Check only 2 Medic<br>one) 1 Certif   | ying Physician: T<br>al Examiner: On<br>and | o the best of my<br>the basis of exan<br>manner stated.                | knowledge, deat<br>nination and/or in | h occurred a<br>vestigation,           | at the time, d                       | late and place,<br>on, death occur            | and due to the<br>red at the time                    | cause(s) and                  | and manner as s<br>place, and due t                 | stated.<br>o the cause(s)                            |
| com  | -         | 29b. Signature and title of cert  | 4   |  |                                       | 29c.                                   | . License nur                        | mber  |  | 29d. Date                     | signed (Month,                                      | Day, Year)   |
| 2)   |           |   |   |  | Stern ODel (T                         |  | 0250                                 | 040   |  | 5                             | 114 08  | ,<br>,   |
| *  |           | 30. Name and address of pers<br>Khosrow Dau   | achi 78                                     | OI OId   | Branc                                 | h Ayo                                  | enue t                               | 44091   | olinto   | n,m                           | D 207   | 35   |
| State  |           | 31. Date filed (Month, Day, Ye MAY 1 5 20   | ns L  | 32. Registrar's Si   | gnature.                              |  |                                      |   |  |                               |   |  |

|                                |  |                 | State of   | Maryland / Dep                               |   |  | lental Hygien                                  | ne   |                           |  |  |  |
|--------------------------------|--|-----------------|--|--|---|--|--|--|---------------------------|--|--|--|
|                                |  |                 | Registrar  | Ce   | ertificate of L   | Death                                    | Reg. N   | ·· 2008                                      | 17462                     |  |  |  |
| н                              | Physicia   | an              | 1. Decedent's Name (First, Middle, Last)  Gerald Dean Sm   | ith Sr.                                      |   |  | 2. Date of Death<br>Month                      | Day Year                                     | 3. Fime of Death          |  |  |  |
|                                | /Medic   |                 | 4a. Facility Name (If not institution, give street and num   |  | 4b. City. Town, or  | Location of Death                        |  | Ic. County of Death                          | 1/3.3 A.                  |  |  |  |
|                                | Examin   | er              | 11111  | the Lake                                     | Sol   | shory                                    |  | Wicom  | ica                       |  |  |  |
|                                | Funeral  |                 | 5. Social Security Number 6. Sex 7   | '. Age (In yrs. last birthda                 | (y) If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.           | 8. Date of Birth<br>(Month, Day, Yea           | 9. Birthn                                    | lace (State or Foreign    |  |  |  |
| П                              | Director   |                 | 214-42-9037  | 62 Yrs.                                      | Wolfins Days  | Hours IVIII.                             | 6/26/194                                       |  | yland                     |  |  |  |
|                                | and w  |                 | Usual Residence of Decedent  10a. State 10b. County  | 10c. City, Town or                           | Location  |  | 9,,  |  | 0d. Inside City Limits    |  |  |  |
|                                | Maryla<br>f sho<br>ed at   | ō               |  | Salis  |   |  |  |  | 1 Ves 2 No                |  |  |  |
|                                | the 28a-   | Director        | Maryland Wicomico  10e. Street and Number  | Dails  | 10f. Zip Code   |  | 10g, C   | Citizen of What Cour                         | itry?                     |  |  |  |
| direc                          | 3a or  |                 | 4801 Snow Hill Road  |  | 2180  | 4  |  | USA  | ,                         |  |  |  |
|                                | be filed within 72 hours after death with the Maryland ttal Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at  | Funeral         | 11. Marital Status 12. Was Deced   | lent Ever in U.S.                            | 3. Was Decedent of Hi<br>If Yes, specify Cuba                             | ispanic Origin? (Sp                      | pecify Yes or No-                              | 14. Race - Americ                            |                           |  |  |  |
| ထ္ထ                            | or Ite   | F               | 1 Never Married 2 A Married 1 Never Married 1 Never Married 2 If Yes. Give   | 2 No   | 1 ☐ Yes 2 X No  | Specify:                                 | ritoan, etc.)                                  | Black, White,                                |                           |  |  |  |
| 8                              | ural",   | d by            |  | tes: Army                                    |   |  |  | WI   | nite                      |  |  |  |
| 5                              | n 72<br>' "nat<br>edlos  | lete            | 15. Decedent's Education (Specify only highest grade completed)  | ı (Gi  | cedent's Usual Occupa<br>ive kind of work done o<br>e. DO NOT use retired | during most of work                      | king 16b.                                      | Kind of Business/In                          | dustry                    |  |  |  |
| 21215-0036                     | withi<br>iene.<br>than   | Completed       | Elementary/Secondary (0-12) College (1-  |  | eer milita  |  | U.   | .S. Army                                     |                           |  |  |  |
| ğ                              | il Hyg<br>other  | BeC             | 17. Father's Name (First, Middle, Last)  |  |   |  | e (First, Middle, Maid                         | en Surname)                                  |                           |  |  |  |
| <u>la</u>                      | uld be<br>Menta<br>rked<br>tic ev  | To B            | William Smith Sr.  |  |   | Evelyn                                   | R. Taylor                                      |  |                           |  |  |  |
| Maryland                       | 2 sho<br>and I<br>is ma<br>auma  | Ė               | 19a. Informant's Name/Relationship (Type. Print)   | I .  | ailing Address (Street a  |  |  |  | Code)                     |  |  |  |
| Σ.                             | and and n 27   |                 | Debra Smith/wife   |  | Ol Snow Hi  |  |  |  |                           |  |  |  |
| ore                            | ges 1<br>t of H<br>If itel   |                 | 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from S   | late   _                                     | sposition (Name of<br>rematory or other place                             |  |  | Location - City or To                        |                           |  |  |  |
| altimore,                      | t. Par<br>rtmen<br>rtant:  |                 | 4 ☐ Donation 5 ☐ Other (Specify)   | Parsons                                      | Cemetery  |  |  | alisbury,                                    |                           |  |  |  |
| Ba                             | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. |                 | 21. Signature of Fureral Service Licensee  | nel  | HOLLOWAY<br>501 Snow  | Funeral H<br>Hill Rd.                    | Home Profes<br>, Salisbur                      | ssional As<br>y, MD 2180                     | ssociation<br>04          |  |  |  |
| Г                              |  |                 | 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on thine.  Approximate Interval Between Onset and Death |  |   |  |  |  |                           |  |  |  |
| 1                              | Physician  |                 | Immediate Cause (Final disease or condition  | ing Can                                      | cer west  | & Duce                                   | r Mitas  | stasis                                       | Unset and Death           |  |  |  |
|                                | /Medical<br>Examiner   |                 | resulting in death)  Due to (co  | or as consequence of):                       |   | 7  |  |  |                           |  |  |  |
| Ž.                             |  | <u>.</u>        | Sequentially list conditions, b.   | ir as a consequence of).                     |   |  |  |  |                           |  |  |  |
| Т                              | nsit   | Examiner        | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  | . as a someoquemes siy.                      |   |  |  |  |                           |  |  |  |
| Ć,                             | execu<br>n and<br>ial-tra  | Exal            |  | or as a consequence of):                     |   |  |  |  |                           |  |  |  |
| 8760,                          | icate be executed<br>physician and<br>the burial-transit   | dical           | d  |  |   |  |  |  |                           |  |  |  |
| ဖ                              | rtifica<br>ng ph<br>as th  | Nedi            | IF FEMALE:   |  |   |  |  |  |                           |  |  |  |
| Box                            | ath ce<br>tendii<br>or use   | an/             | 23h Was decedent progrant 23c. If yes, outo  | ome pf pregnancy<br>rth 2  Fetal death :     | 3 □Ectopic pregnancy  | ,  |  | 23d. Date of deliv                           | ,                         |  |  |  |
| <u>.</u>                       | ie dea<br>the at<br>hed fo   | sici            | 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown   |  | 5 ☐ Other (specify)   |  |  | Month Day Year                               |                           |  |  |  |
| <u>Ч</u>                       | uires that the death certifit<br>signed by the attending t<br>d be detached for use as   | by Physician/Me | Part II. Other significant conditions contributing to de-  | ath but not resulting in the                 | e undertving cause give   | en in Part I.                            | 23e. Did tobacc                                | o use contribute to t                        | he cause of death?        |  |  |  |
| ds,                            | signe<br>d be  | d b             | Essential Hype   | eleusion                                     |   |  |  | Yes 2 No 3 Probably 4 Manhow                 |                           |  |  |  |
| Ö                              | w requir<br>been si<br>should  | ete             | Slacke   |  |   |  | 24a. Was an                                    | 24b. Were autopsy findings available         |                           |  |  |  |
| Š                              | he lav<br>e has<br>ige 2   | Completed       | o fack   |  |   |  | autopsy<br>performed                           | prior to co<br>death?                        | mpletion of cause of      |  |  |  |
| <u>ra</u>                      | in: T<br>ificate<br>or, pa   |                 | 25. Was case referred to medical   |  |   | Of Diago of Dag                          | 1  Yes 2  th (Check only one)                  | No 1 ☐ Yes                                   | 2 <b>₫</b> No             |  |  |  |
| >                              | ysicía<br>s cert<br>direct   | To Be           | examiner?  | npatient 2 ☐ ER/Outpat                       | tient 3 DOA Othe  | er.                                      |  | 6 COther (Speci                              | on Hospice                |  |  |  |
| 0                              | ig Ph<br>ter thi   |                 | 27. Manner of Death 28a. Date of Manti   |  | e of 28c. Injur   |  | lursing Home 5 ☐ Residence 6 🖬 Other (Specify) |  |                           |  |  |  |
| jo                             | endin<br>ath.<br>or: Af  | atio            | 2 Accident investigation   | , bay reary                                  |   | Yes 2 □ No                               |  |  |                           |  |  |  |
| Division or Vital Records, P.O | r Atterder de irectorde by ti  | Certification:  | 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place buildin  | of injury - At home, farm, g, etc. (Specify) | street, factory, office   |  | 28f. Location (Street<br>City or Town, St.     | and Number or Run                            | al Route Number,          |  |  |  |
|                                | ortal c  |                 |  |  |   |  |  |  |                           |  |  |  |
|                                | To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending to completely filled in by the funeral director, page 2 should be detached for use as              | Medical         | 29a. Certifier (Check only one)  1 Certifying Physician: To the 2 Medical Examiner: On the ba and mann   | sis of examination and/or                    | eath occurred at the tir<br>r investigation, in my o                      | ne, date and place<br>pinion, death occu | red at the time, date                          | e(s) and manner as s<br>and place, and due t | stated.<br>o the cause(s) |  |  |  |
|                                | To the To the To the To the To the Compl   | Me              | 29b. Signature and title of certifier  | 200 /  | 29c. Licens   | e number                                 | 29d. I   | Date signed (Month,                          | Day, Year)                |  |  |  |
|                                | 1114   |                 | Megan h. Be  | Class h                                      | D DZ  | 9505                                     | - 0  | 5 -11 -                                      | 08                        |  |  |  |
|                                | 8418   |                 | 80. Name and address of person who completed cause   | of death (Item 23a) (Tyr                     | pe, Print)  |  |  |  |                           |  |  |  |
|                                | v  |                 | GREGORIO M. BELLOS   | 0, M.D.; 53                                  | 02 CHINABI  | ERRYDR                                   | . SALISBU                                      | RY, MD                                       | 21801                     |  |  |  |
|                                | Sta<br>Registi   |                 | 31. Date filed (MONTA Pay 1 Year) 2008 38  | egistrar's Signature                         | book  |  |  |  |                           |  |  |  |

|            |   |                          | 1 - For<br>State<br>Registrar  | State of Maryland   | d / Depa<br><i>Ce</i>                   | artment of H<br><i>rtificate of L</i>                        | ealth and M<br>Death                                    | lental Hyg  | giene 0        | 08                  | 17463  |
|------------|---|--------------------------|--|---|---|--|---|---|----------------|---------------------|--|
|            | Physici   | an                       | Decedent's Name (First, Middle, Last)     T  | 0.1.1   | Contab                                  |  |   |   |                | Year                | 3. Time of Death                                   |
| v          | /Medic  | al                       | Helen Jeannette  |   |   | 1 0 T  | Landing of Cooth  | May 9   |                | 008<br>ity of Death | 10:00p M   |
| 4          | Examin  | er                       | 4a. Facility Name (If not institution, give: 7200 Third Ave.   | C-129   |   | Sykes  | Location of Death                                       |   |                | ro11                | '  |
|            | Funeral   |                          | 5. Social Security Number 6. Sec   | 7. Age (In yrs. la  | st birthday)                            | ff Under 1 Year<br>Months Days                               | If Under 24 Hrs. Hours Min.                             | 8. Date of Birth<br>(Month, Day   |                | 9. Birth            | place (State or Foreign                            |
|            | Director  |                          |  | <sup>1M 2</sup> √x 86   | Yrs.                                    | Widitiis Days  |   | June 5  | 1921           | MD                  |  |
|            | land w  |                          | Usual Residence of Decedent  10a. State 10b. County  | 10c. City,  | Town or Lo                              | ocation  |   |   |                | T                   | 10d. fnside City Limits                            |
|            | Mary<br>a-f sh  | tor                      | MD Carroll   | Sy  | kesvi                                   | 11e  |   |   |                |                     | 1 Yes 2 □ No                                       |
|            | or 28,  | Director                 | 10e. Street and Number   | 0.100   |   | 10f. Zip Code  |   |   | 10g. Citizen o | f What Cou          | intry?   |
|            | s 23a   | rail                     | 7200 Third Ave.  | C-129   |   | 21784  | i- O-i-i-0 (C   | at. Vac as No   | USA            | 700 Amor            | ican Indian.                                       |
| 336        | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment must be notified at once. | by Funerai               | 11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  | 12. Was Decedent Ever in U.S<br>Armed Forces?<br>1 ☐ Yes 2 ☐ No<br>If Yes, Give<br>Year or Dates: |   | was Decedent of Hi<br>If Yes, specify Cuba<br>1 ☐ Yes 2 ☑ No | spanic Origin? (Spe<br>n, Mexican, Puerto I<br>Specify: | Rican, etc.)  |                | ack, White          |  |
| 2-0        | 72 hot  | ted                      | 15. Decedent's Edu<br>(Specify only highest grade  | cation  | 16a. Dece                               | dent's Usual Occupa  | ation   | na  | 16b. Kind of   | Business/I          | ndustry  |
| 21215-0036 | d within 7<br>giene.<br>ar than "r  | Completed                | Elementary/Secondary (0-12)  | College (1-4or 5+)  |   | nemaker  | furing most of workii<br>)                              |   | dome           | estic               |  |
| pu         | be file<br>tal Hy<br>d oth  | Be                       | 17. Father's Name (First, Middle, Last)  Edmund Woolfend   |   |   |  | 18. Mother's Name                                       |   |                | ате)                |  |
| Maryland   | d Men<br>d Men<br>narka<br>natic  | 2                        | 19a. Informant's Name/Relationship (Ty   |   | 10h Maili                               | ng Address (Street   | Estella<br>and Number or Rura                           |   |                | m State 7           | in Code)   |
| Ma         | nd 2 s<br>lith an<br>27 is i  |                          | Dr. Robert Bastres   |   |   |  |   |   |                | ., o.b.o, 2         | <i>p</i> 3343,                                     |
| Jre,       | of Head   |                          | 20a. Method of Disposition   | 20b. Pla  | ace of Dispo                            | osition (Name of   | e)   D  | ate   | 20c. Location  | n - City or T       | own, State   |
| Ē          | Page<br>ment ant: It  |                          | 1)∏ Burial 2 ☐ Cremation 3 ☐ F<br>`4 ☐ Donation 5 ☐ Other (Specify)  | emoval from State Cres  | st Law                                  | n Memoria  | il   5–13-  | -   |                |                     | lle, MD  |
| Baltimore, | permit. Departr Imports any inju  |                          | 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & CP P.O. Box 195 Sykesville, MD 21784 |   |   |  |   |   |                |                     |  |
|            | Physician<br>/Medical<br>Examiner   |                          | 23a. Part1. Enter the disease, or compl<br>shock, or heart faifure. List only or   | cations that caused the death.  | . Do not en                             | ter the mode of dyin   | g, such as cardiac o                                    | r respiratory ar  | rest,          |                     | Approximate<br>Interval Between<br>Onset and Death |
|            |   |                          | Immediate Cause (Final disease or condition resulting in death)  | Diabetes  | 3 4                                     | ype II   |   |   |                |                     | years  |
|            |   |                          | 1  | Due to (or as a consequ   | ence of):                               | O  |   |   |                |                     | 0  |
|            |   | ner                      | Sequentially list conditions, if any, leading to immediate   | Due to (or as a consequent  | ence of):                               |  |   |   |                |                     |  |
|            | scuted<br>ind<br>transii  | Examiner                 | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):    |   |   |  |   |   |                |                     |  |
| 38760,     | icate be executed<br>physician and<br>s the burial-transit  | ai E                     | Due to (or as a consequence of):   |   |   |  |   |   |                |                     |  |
| 687        |   | edicai                   |  |   |   |  |   |   |                |                     |  |
| P.O. Box   | that the death certifi<br>ed by the attending<br>detached for use as  | Completed by Physician/M | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  | -   | 23d. Date of delivery<br>Month Day Year |  |   |   |                |                     |  |
|            | res that<br>igned by<br>be deta   | y Ph                     | Part II. Other significant conditions cor  | en in Part I.   | 23e. Did to                             | bacco use co   | co use contribute to the cause of death?                |   |                |                     |  |
| ords       | w require<br>been sig<br>should b   | ted t                    | hypertension   |   |   |  |   | 1 🗆 Y   | es 2 No        | 3 🗆 Pro             | bably 4 Dunknown                                   |
| I Records, | The law requires that the ate has been signed by the page 2 should be detache   | Comple                   | hyperlipiden   | úa  |   |  |   | 24a. Was autop<br>perfor<br>1 ☐ Yes   |                |                     |  |
| of Vital   | ician;<br>sertific<br>ector,  | Be                       | 25. Was case referred to medical examiner?   | Inenital:   |   | other all DOA Other  | 26. Place of Death                                      |   |                |                     |  |
| o          | Phys<br>r this<br>ral dir   | . To                     | 1 Yes 2 No   | 28a. Date of Injury   | R/Outpatie<br>28b. Time o               | IL SLIDOA  | 4   Nuisirig Hoi  | me 5 PResid<br>28d. Describe h  |                |                     | ify)   |
| ion        | Attanding<br>ir death.<br>actor: Atter<br>by the fune   | ation                    | 1 Natural 5 ☐ Pending<br>2 ☐ Accident investigation  | (Month, Day Year)   | Injury                                  | Work   | res 2 □No   |   |                |                     |  |
| Division   | al or Atta<br>s after des<br>il Diracto<br>id in by th  | Certification:           | 3 Suicide 6 Could not be<br>4 Homicide determined  | 28f. Location (Street and Number or Rural Route Number,<br>City or Town, State)                   |   |  |   |   |                |                     |  |
|            | To the Hospital or Attanding Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.   | edical C                 |  |   |   |  |   | ace, and due to the cause(s) and manner as stated. ccurred at the time, date and place, and due to the cause(s) |                |                     |  |
|            |   | Me                       | 29b. Signature and title of centifier  | T . As  |   | 29c. License   | number  |   | 29d. Date sign | ned (Month          | , Dey, Year)                                       |
| •          | WST   |                          | - Chill  | M.)   |   | 7) 31  | 4847  | /   | May            | 12                  | 2008   |
|            | 15  |                          | 30, Name and address of person who co  |   |   | perty Ro   | +849<br>lad Eld.  | esburg  | MD             | 21                  | 784  |
|            | Sta<br>Registr  |                          | 31. Date filed (Month, Day, Year)  MAY 1 3 2   | 32. Registrar's Signation   |   | bout   |   |   |                |                     |  |

| Helen Marie Spark  |                | State of Maryland / Department  | of Health and Mental H   |  | 200                                    | 8 1746                       |  |  |  |  |  |
|--|----------------|---|--|--|--|------------------------------|--|--|--|--|--|
|  |                | - For State Certificate   | of Death   |  | . No.                                  |                              |  |  |  |  |  |
| Physician<br>Medical Examin  | U/             | 1. Decedent's Name (First, Middle,Last)  Helen Marie Sparks   |  | 2. Date of Death<br>Month<br>May 10, 200 | Day Year<br>08                         | 3. Time of Death<br>1354 hrs |  |  |  |  |  |
| Ca.  |                | 4a. Facility Name (if not institution, give street and number)  | 4b. City, Town, or Location of Death   |  | 4c. County of Death                    |                              |  |  |  |  |  |
|  |                | Union Hospital  | Elkton   | lo Data of Blats                         | Cecil                                  | -1 (01-1                     |  |  |  |  |  |
| Funeral Director   | 1              | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 529–92–4294 1 M 2 X F 46   | Months Days Hours Min  |  | Foreign                                |                              |  |  |  |  |  |
|  | ŀ              | Usual Residence of Decedent   | Yrs.   | Dec. 25                                  | , 1961                                 | <sup>ntry)</sup> Idaho       |  |  |  |  |  |
| v any  | O L            | 10a. State 10b. County 10c. City, Town or L   | ocation  |  |  | 10d. Inside City Limits      |  |  |  |  |  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.   |                | Maryland Cecil  | North East   |  |  | 1 X Yes 2 No                 |  |  |  |  |  |
| Mary r. 28a-   |                | 10e. Street and Number  | 10f. Zip Code  | 100                                      | g. Citizen of What Coun                | •                            |  |  |  |  |  |
| ith the 33a c  |                | 61 Sycamore Drive  11. Marital Status   12. Was Decedent Ever in U.S.   13  | . Was Decedent of Hispanic Origin? (Sp   | pecify Vec or No-                        | U.S.A                                  |                              |  |  |  |  |  |
| eath w   | Funeral        | 1 Never Married 2 Married Armed Forces?   | If Yes, specify Cuban, Mexican, Puerto   |  | White, etc.                            | an muan, black,              |  |  |  |  |  |
| after dal", or   | g<br>F         |   | Yes 2 X No specify:  |  | Specify:                               | White                        |  |  |  |  |  |
| hours  |                | 15. Decedent's Education (Specify only highest grade completed) 16a. Dece   | edent's Usual Occupation (Give kind of<br>ing most of working life. DO NOT use ret |  | 16b. Kind of Business/Ir               | dustry                       |  |  |  |  |  |
| 36<br>in 72<br>han "   | Completed      | Elementary/Secondary (0-12) College (1-4 or 5+)  Twelve Years   |  | ,  | Cytec<br>Havre de Grad                 | e. Marvland                  |  |  |  |  |  |
| 215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica   | 틹              | 17. Father's Name (First, Middle, Last)   | Laborer  18.Mother's Name  | (First, Middle, Ma                       |  |                              |  |  |  |  |  |
| 215<br>be file<br>ntal H-<br>rked o  | Be             | Jerry Trachsel  |  | eggy Hir                                 | •                                      |                              |  |  |  |  |  |
| 21;<br>hould then and Men<br>is mar  | _ 1            |   | - '  |  | Number, City or Town, State, Zip Code) |                              |  |  |  |  |  |
| MD 2 shot and 2 shot and 2 shot and 27 is  |                |   | Rustic Court, Per  | ryville,                                 | Maryland  20c. Location - City or      |                              |  |  |  |  |  |
| Baltimore,<br>permit. Pages 1 at<br>Department of the<br>Important: If ite   |                | 1 Burial 2 X Cremation 3 Removal from State crematory   | or other place)  |  | •                                      |                              |  |  |  |  |  |
| Itimen urtmen primit y or o  |                | Donation 5 Other Specify.   | · I ·  | /13/08                                   | •                                      | Pennsylvania                 |  |  |  |  |  |
| Ba<br>perm<br>Depa<br>Imp  |                | More M Trueson Kr.  | Son Fun  | eral Home,<br>3-0766                     | P.A.                                   |                              |  |  |  |  |  |
| Physician  | 1              | 23a. Part I. En ar the disease, o complications that caused he be th. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and |  |  |  |                              |  |  |  |  |  |
| /Medical<br>xaminer  | -              | Immediate Cause (Final disease a. Multiple Gunshot Wounds   |  |  |  |                              |  |  |  |  |  |
|  | -              | or condition resulting in death)  Due to (or as a consequence of):  |  |  |  |                              |  |  |  |  |  |
|  | 盲              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):   |  |  |  |                              |  |  |  |  |  |
| .5   | Examiner       | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):   |  |  |  |                              |  |  |  |  |  |
|  |                | d.  |  |  |  |                              |  |  |  |  |  |
| be exe   | gica           | UNPENDED  |  |  |  |                              |  |  |  |  |  |
| 68760, certificate b nding physise as the but  | ١              | IF FEMALE: 23c. If yes, outcome of pregnancy Live birth   | Fetal death 3 Ectopic pregn  |  | 23d. Date of delivery                  |                              |  |  |  |  |  |
| n of Vital Records, P.O. Box 68760 ing Physician: The law requires that the death certificate the this certificate has been signed by the attending physimeral director, page 2 should be detached for use as the burneral director.   | Physician/Me   | past 12 months?  4 Pregnant at time of death 5  | Fetal death 3 Ectopic pregn  Other (Specify)                                       | aricy                                    | Month Day Year                         |                              |  |  |  |  |  |
| Box he death of the attent of the attent hed for us  | Š              | 1 Yes 2 No 9 V Unknown 9 Unknown  |  | Loo. Billio                              | 1                                      |                              |  |  |  |  |  |
| P.O.   | ھ              | Part II. Other significant conditions contributing to death but not resulting in  | the underlying cause given in Part I.  |  | 2 ✓ No 3 Prob                          |                              |  |  |  |  |  |
| ds,<br>equire<br>een sig   | Completed      |   |  | 24a. Was a                               |  | opsy findings available      |  |  |  |  |  |
| of Vital Records, ng Physician: The law require ufter this certificate has been si meral director, page 2 should b   | 힑              |   |  | autops<br>perforr                        | ned? death?                            | ompletion of cause of        |  |  |  |  |  |
| The riffcat or, page   |                | 25. Was case referred to medical  | 26.Place of Death (Check   | 1 Yes 2                                  | . No 1 ✓ Ye                            | s 2 No                       |  |  |  |  |  |
| Vita<br>ysicia<br>his cer<br>direct  | e Be           | examiner?  1 Ves 2 No Hospital: 1 Inpatient 2 V ER/Outpa  | TOther:  |  | Residence 6 Other                      | :                            |  |  |  |  |  |
| n of V   | - 1            | 27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time  | e of Injury 28c. Injury at Work?   | 28d. Describe he<br>Subject shot         | ow injury occurred                     | ·                            |  |  |  |  |  |
|  | Certification: | 2 Accident Investigation  | 1 163 2 4 110  |  |  |                              |  |  |  |  |  |
| DIVIS  | Ĭ              | 3 Suicide 6 Could not be determined (Specify) Single Family   | street, factory, office building, etc.   | or Town, St                              |  |                              |  |  |  |  |  |
| Di Hospital 24 hours a Funeral etely filled  |                | 29a. Certifier 1 Continue Physician To the best of my legaridade doubt.   | pecuman at the time, date and place, and   |  | Road, North East, MI                   |                              |  |  |  |  |  |
| Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the bine and the detached for use and the deta | Medical        | (Check only one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.   |  |  |  |                              |  |  |  |  |  |
| E > E 8  | ŝ              | 29b. Signature and title of certifier   | 29c. License number  |  | 29d. Date signed (Moi                  | nth, Day, Year)              |  |  |  |  |  |
|  |                | for Jey Mo  | O.C.M.E.   |  | May 11, 2008                           |                              |  |  |  |  |  |
| 1100   |                | 30. Name and address of per in who completed called of death (Item 23a)  Tasha Greenberg MD. Assistant Medical Examiner   | I11 Penn Street, Baltimore, M  | D 21201                                  |  |                              |  |  |  |  |  |
| Sta  | te.            | 31. Date filed (Month, Day, Year)  32. R gistrar's Signature  | TTT F CHIT Street, Baltimore, M  |  |  |                              |  |  |  |  |  |
| Ota  |                | MAY 1 / 7008   Marin 1  |  |  |  |                              |  |  |  |  |  |

State of Maryland / Department of Health and Mental Hygiene 2 8 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Evelyn Marco Strubel 10 10:30 AM 2008 May /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Somerford Place Annapolis Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 M 2 X 051-16-8670 87 21, New York Director Oct. 1920 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it e Modell Examited inset to relified at 10d. Inside City Limits 10a. State 10h County 10c. City. Town or Location Maryland Anne Arundel Annapolis **Funeral Director** 1 ☐ Yes 2 ☐No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21403 3104 Droque Court U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2 XNo White Specify Completed by 3XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Office Manager Advertising Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Marco Mary Clissa 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Lynch/daughter 3104 Droque Court Annapolis, Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department or Important; If any injury or Holy Rood Cemetery 5/15/2008 Westbury, New York 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** advanced ears disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor 1 □Yes 2 □No Month Year 5 Other (specify) 9 Unknown icate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hiknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 certificate 2 🗆 No 1 □Yes 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 28c. Injury at Work? 1 Natural
2 Accident 5 Pending investigation 1 ☐Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifie Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Huy Millersville MD 31. Date filed (Month, Day, Year) MAY 1 3 2008

State Registrar

3altimore, Maryland 21215-0036

P.O. Box 68760.

Division of Vital Records,

|                                |   |                       | 1 _ State   | ite of Marylan   |                                | artment of l  |  | Mental Hy                                 | _  |  |   |  |   |  |
|--------------------------------|---|-----------------------|---|--|--------------------------------|---|--|---|--|--|---|--|---|--|
| ľ                              | Db  |                       | Registrar  1. Decedent's Name (First, Middle, Last)   |  |                                | inicate or  | Death  | 2. Date of D                              | Reg. No.<br>eath<br>Day  | 2000   | 3. Time of Death                                  |  |   |  |
| 1                              | Physici<br>/Medio   |                       | THELMA D  | ),   | 4                              | SOUDER  |  | May                                       | 12   | 2 2003   | 1830 PM   |  |   |  |
|                                | Examir  | er*                   | 4a. Facility Name (If not institution, give street a Shady Grove Adventis   |  |                                | Rocl  | or Location of De  |   | 4c.  | Montgo   |   |  |   |  |
|                                | Funeral<br>Director   |                       | Social Security Number     212-68-6726     Usual Residence of Decedent  | 7. Age (In yrs. I  | ast birthday)<br>Yrs.          | If Under 1 Year<br>Months Days                              | If Under 24 H<br>Hours Mi  |   | ay, Year)  | Coi  | nplace (State or Foreign<br>Intry)<br>hington,D.C |  |   |  |
|                                | yland<br>now<br>at  |                       | 10a. State 10b. County  | 10c. City  | , Town or Lo                   | cation  |  |   |  | _  | 10d. Inside City Limits                           |  |   |  |
|                                | e Mar<br>8a-f sh<br>ptified   | ctor                  | Md. Montgomery  | 7  | Rockvi                         | lle   |  |   |  |  | 1 ☐ Yes 2 No                                      |  |   |  |
|                                | 3a or 2   | I Dire                | 10e. Street and Number<br>9523 Veirs Drive,   | 1  |                                | 10f. Zip Code   | 20850  |   |  | izen of What Cou<br>nited St                       | •   |  |   |  |
| 9036                           | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. | d by Funeral Director | 1 Never Married 2 Married 1 If  | as Decedent Ever in U.<br>med Forces?<br>Yes 2'M No<br>res, Give<br>ar or Dates: | A. 20-4 20                     | 1□Yes 2 <mark>X</mark> No                                   | Specify:   | (Specify Yes or Nerto Rican, etc.)        |  |  |   |  |   |  |
| <b>1215-(</b><br>within 72 h   | within 72 h<br>ene.<br>than "natu<br>ne Medica  | Completed by          | 15. Decedent's Education (Specify only highest grade comp   | oleted)<br>ollege (1-4or 5+)   | (Give<br>life.                 | dent's Usual Occu<br>kind of work done<br>DO NOT use retire | during most of v   | vorking                                   | 1  | 16b. Kind of Business/Industry                     |   |  |   |  |
| Baltimore, Maryland 21215-0036 | d be filed vental Hygic<br>ked other i<br>c event, th   | To Be Co              | 17. Father's Name (First, Middle, Last)  Harvey Brake   | O .  | emaker                         | lame (First, Middle   | e, Maiden  | Own Home                                  | e  |  |   |  |   |  |
| Mary                           | nd 2 shoul<br>lith and M<br>27 is marl<br>r traumati  | ř                     | 19a. Informant's Name/Relationship (Type. Pr. Kathryn V. Plank / D  |  | 1                              | ng Address (Stree   |  | Rural Route Num<br>Denton ,               | ber, City o  | or Town, State, Z<br>21629                         | (ip Code)   |  |   |  |
| more,                          | Pages 1 arent of Hesent of Hesent of the rut: If item   |                       | 20a. Method of Disposition  1 M Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)  | al from State  | emetery, cre                   | sition (Name of<br>matory or other plants                   |  | Date /19/08                               |  | ocation - City or                                  | Town, State                                       |  |   |  |
| Balti                          | permit. Departm Importal any Inju   |                       | 21. Signature of Funeral Service Licensee   | when   |                                | 2. Name and Add<br>Muriel                                   | ess of Facility<br>H. Barbe  | er Funera                                 | al Ho  | ome  | 20882   |  |   |  |
|                                | Physician   |                       | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition   | s that caused the death<br>se on each line.                                      | ,                              |   |  | liac or respiratory                       |  |  | Approximate Interval Between Onset and Death      |  |   |  |
|                                | /Medical<br>Examiner  |                       | resulting in death)   | Due to (or as a consequence of Supersise   |                                | unury   | 277631   |   |  |  | one day   |  |   |  |
| ,<br>,                         | cate be executed oblysician and the burial-transit  | Examiner              | Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (fr as a consequence of):  C  |  |                                |   |  |   |  |  |   |  |   |  |
| 68760,                         | ificate be<br>g physicia<br>as the buri   | dical                 | d   |  |                                |   |  |   |  |  |   |  |   |  |
| .O. Box                        | The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit  | Physician/Me          | ysician/N   | ysician/N  | ysician/N                      | in the past 12 months?                                      | yes, outcome pf pregna<br>□Live birth 2 □ Feta<br>□Pregnant at time of d<br>□Unknown | Ideath 3[                                 | □Ectopic pregnan<br>□ Other (specify)  | oy   |   |  | 23d. Date of delivery<br>Month Day Year |  |
| rds, P.                        | w requires that the d<br>been signed by the<br>should be detached   | d by Pł               | Part II. Other significant conditions contribute  | ing to death but not resi  | ulting in the u                | nderlying cause g   | iven in Part I.  |   | Did tobacco use contribute to the cause of death'<br>1 □ Yes 2 ☑ No 3 □ Probably 4 □ Unkno |  |   |  |   |  |
| Division or Vital Records,     | sician: The law re<br>certificate has bee<br>rector, page 2 sho   | Completed by          |   |  |                                |   |  | per                                       | s an<br>opsy<br>formed?<br>2 Mo  | prior to death?                                    | topsy findings available completion of cause of   |  |   |  |
| <b>Vit</b>                     | Physician:<br>r this certific<br>ral director,  | Be                    | 25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No Hospita  | al: 4 5  | FD/Outs-Nov                    | 4 25 504 0  | ther:  | Death (Check only                         |  | . 5  |   |  |   |  |
| on or                          | Ilng<br>Afte<br>fune  | tion: To              |   | a. Date of Injury (Month, Day Year)  | 28b. Time of<br>Injury         | of 28c. Injury at 28d. Descrit                              |  |   | lesidence 6 □Other (Specify) be how injury occurred  |  |   |  |   |  |
| Divisi                         | or Atter<br>fter deal<br>Director<br>in by the  | Certification:        | 2 Accident 3 Suicide 4 Homicide  Could not be determined  28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Rucky)  City or Town, State)  |  |                                |   |  |   |  | ıral Route Number,                                 |   |  |   |  |
|                                | To the Hospital within 24 hours a To the Funeral I completely filled  | Medical C             | 29a. Certifier (Check only one) 1 ☑ Certifying Physician 2 ☐ Medical Examiner: Cartifying Physician 2 ☐ Medica | : To the best of my kno<br>on the basis of examina<br>and manner stated.         | wledge, deat<br>tion and/or in | h occurred at the   | time, date and pl  | ace, and due to th<br>ccurred at the time | e cause(s<br>e, date an  | ) and manner as<br>d place, and due                | s stated.<br>e to the cause(s)                    |  |   |  |
|                                | To t<br>With<br>To t  | Σ                     | 29b. Signature and title of certifier  Dinfy Clay   | M.D.   |                                |   | 29c. License number  D 0065505   |   |  | 29d. Date signed (Month, Day, Year) M 114 13, 2008 |   |  |   |  |
|                                | 5   |                       | 30. Name and address of person who complete   | ed cause of death (Item  | 123a) (Type,                   | Print)<br>Center  | drive.   | Rocku                                     | :114   | , MD   |   |  |   |  |
| ľ                              | Sta<br>Regist   |                       | 31. Date filed (Month, Day, Year) 1 5 2   | 9901/32. Registra & Signa  | iture #                        | Small   | ,  |   |  |  |   |  |   |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 11, Day 2008 MAY **Physician** STROUPE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** FREDERICK MEMORIAL FREDERICK HOSPITAL FREDERICK If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 F Days Hours Yrs 66 19,1942 Kentúcky 236-60-6441 Jan. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 🏖 No Directo Maryland Frederick Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21704 5912 Quinn Orchard Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗓 No Specify. Completed by 3 MWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) I Hygiene. other than " College (1-4or 5+) Elementary/Secondary (0-12) Medical Clerk Healthcare +2 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stella Potton Homer Bolen 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5912 Quinn Orchard Rd., Frederick, MD 21704 Jane Ramey / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any Injury or o 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 5/15/2008 Lovettsville Union Lovettsville, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Funeral Home of Funeral Service License 22. Name and Address of Facility 21. Signat 1100 North Maple Ave., Brunswick, MD 21726 se, or complications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. *[au* Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Assysta /Medical Due to (or as a consequence of) Examiner Acuto Sequentially list conditions, if any, leading to immediate cause. Enter ordershing Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed sician and burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the attending properties for use as as 23c, if yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a 1 ☐ Yes 2 ☐ No O 9☐Unknown 9 Unknown signed by <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed certificate | 1□ Yes 2☑No Division or Vital 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 4 100 1 Inpatient 2 ER/Outpatient 3 DOA 10 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t ospital or Attending hours after death. 5 Pending investigation 1 - Natural in 24 hours atter voc....the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

State

10

within 24

29b. Signature and title of certifier

Mydysor 31. Date filed (Month, Day, Year)

100 TO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5 2008

Registra DHMH 17 Rev 1/2001 7 A St

29c. License number

MDD66166

Fredrik Mennied

29d. Date signed (Month, Day, Year)

and manner stated.

Raza

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** T. nd ley M Clouda /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Security Number MEDICAL Sqlisbyns WICOMICO If Under 1 Year | Af Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F Months Days Hours Min. 225-96-5638 Delaware Director 8-1962 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Neulcal Evanture must be notified at Funeral Director 1 Ves 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3180 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 □Yes 2 👿 No Black Specify: Completed by Specify: Hygiene. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Showell Poultre aborer 12 Pages 1 and 2 should be filed vent of Health and Mental Hygis ant: If Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harais/boutriend 1001 Mohawk Ave. Salisbury, MD 21801 Baltimore, 20a. Method of Disposition Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If It any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bishopville, MD Golden Acres 5-17-08 4 ☐ Donation 5 ☐ Other (Specify) era Service Licensee 22. Name and Address of Facility 917 W. Isabella Street Bennie Smith Funeral Home Salisbury, MD 21801 23a. Part 1. Enter into disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 45 Dagesta disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner Athero col if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Completed by Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) P.O. Box 68760. physician IF FEMALE: yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. should be 3 Probably 4 Unknown 1 🔼 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑No 24a. Was an autopsy performed? 1 Yes 2 No this certificate in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 X No Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation dealh. 1 ☐ Yes 2 ☐ No 2 Accident after deail 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital e Funeral file Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

BIOI Callibury

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Y 1 3 2008

08-03713 Lori Lynn Thompson

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

17469 2008

| T Lythi Thomps   |                | For State   |   | Cert                                       | ificate of                      | Death                                    |                             |               |                        | g. No.                   | -                       |   | 1770               |
|--|----------------|---|---|--|---------------------------------|--|-----------------------------|---------------|------------------------|--------------------------|-------------------------|---|--------------------|
| Physician  |                | egistrar<br>Decedent's Name (First, Midd  |   |  |                                 |  |                             | N.            | ate of Deat            | Day                      | Year                    | 3. Time of De<br>1625 hr                |                    |
| edical Examine   | er             | Lori Lynn Th  |   |  |                                 | 4b. City, Town, o                        | - Laustian of               |               | lay 15, 20             |                          | ounty of De             |   |                    |
|  | 4              | a. Facility Name (if not institute 2053 Druid Park Drive                        |   | umber)                                     |                                 | Baltimore                                | Location of                 | Deau          |                        | 10.01                    | ,,                      |   |                    |
|  |                | . Social Security Number  | 6. Sex                                    | 7. Age (In yrs. la                         | st hirthday)                    | If Under 1 Ye                            | ar If Under                 | 24Hrs. 8.     | . Date of Birt         | h(MM/DD                  | /YYYY) 9.               | Birthplace (State                       | or                 |
| Funeral<br>Director  | - 1            | 215-02-1400   | 1 M 2XF                                   |  | 8 Yrs                           | Months Da                                |                             | Min           | 8/30/                  |                          | For                     | reign<br>Country) N                     |                    |
| Director   | - 1            |   | 1 M 2 F                                   |  |                                 | 5.                                       | <u> </u>                    |               | 0/30/                  | 1,0,                     |                         |   |                    |
| á  |                | Sual Residence of Decedent  0a. State 10b. County                               |   | 10c. City,                                 | Town or Loca                    | tion                                     |                             |               |                        |                          |                         | 10d. Inside (                           |                    |
| - 10 M   | . 1            | 0a. State 10b. County   |   | На   | mden                            |  |                             |               |                        |                          |                         | 1 X Yes                                 | 2 No               |
| ryland<br>ra-f sh  | ᅙᆉ             | 0e. Street and Number   |   |  |                                 | 10f. Zip Code                            |                             |               | 1                      | 0g. Citizer              | n of What C             | Country?                                |                    |
| he Ma<br>in or 28  | Director       | 4227 Newport  | - Δυρ. 1st                                | floor A                                    | nt.                             | 21:                                      | 211                         |               |                        |                          | US                      | SA                                      |                    |
| eath with the Maryland items 23a or 28a-f show any ust be notified at once.  | ᅙᅡ             | 1. Marital Status   | 12. Was D                                 | ecedent Ever in U.                         | S 13 W                          | as Decedent of H<br>Yes, specify Cub     | ispanic Orig                | in? (Specif   | fy Yes or No           | - 14                     | Race - Ar<br>White, etc | merican Indian, B<br>c.                 | lack,              |
| leath with   | Funeral        | 1 X Never Married 2   | Yes                                       |  | - 1                             |  |                             | 1 4010 140    | , ,                    |                          | T                       | The diam of                             |                    |
| after of all, of   | <u>8</u> -     |   | ivorced If Yes, Give Y                    |  |                                 | Yes 2 X N                                |                             | and of work   | done                   |                          |                         | White                                   |                    |
| nours  |                | 15. Decedent's Education (Sp  |   |  | 16a. Decede<br>during i         | nt's Usual Occup<br>nost of working li   | fe. DO NOT                  | use retired   | )                      | 102.1411                 | Q 01 200                | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |                    |
| 6 n 72 h   | ompleted       | Elementary/Secondary (0-12  | () College                                | (1-4 or 5+)                                | Г                               | ancer                                    |                             |               |                        | Ent                      | erta:                   | inment                                  |                    |
| withi<br>withi<br>giene.   | 影              | 17. Father's Name (First, Middl   | e. Last)                                  |  |                                 |  | 18.Mother                   | 's Name (Fi   | irst, Middle,          | Maiden Su                | urname)                 |   |                    |
| 215-0036<br>be filed within 7<br>ntal Hygiene.<br>rked other than<br>ent, the Medica   | ွျ             | John Richard  |   | n III                                      |                                 |  |                             | net Bo        |                        |                          |                         |   |                    |
| 212<br>ould be<br>Ment<br>mark   | <u>ه</u> ا     | 19a. Informant's Name/Relation  | nship (Type, Print)                       |  |                                 | ng Address (Str                          |                             |               |                        |                          | or Town, S              | State, Zip Code)                        |                    |
| MD  Id 2 sho  Ilth and  m 27 is  aumati  |                | Janet Thomps  | son Mot                                   | ner  | 313                             | Buskin                                   | Ct. Se                      | vern,         | MD 2<br>Date           | 1144                     | ocation - Ci            | ty or Town, State                       |                    |
| re, l<br>l and<br>Heal<br>fitem<br>er tra  |                | 20a. Method of Disposition  1 X Bunal 2 Cremati                                 |   | 1 from State                               | crematory or                    |  |                             |               |                        |                          |                         |   | 1                  |
| Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.  |                | 4 Donation 5 Other  |   | Res  |                                 | en Cemet                                 |                             |               |                        |                          |                         | en, PA                                  |                    |
| altii<br>mit.<br>partm<br>ports  | 1              | 21. Signature of Euneral Service  | ce Licensee                               |  |                                 | Name and Addr                            |                             |               |                        |                          |                         |   |                    |
| <b>a</b> 89 T.E.   |                | 23a. Part I. Enter the disease,   |   | t arrived the death                        | Do not ente                     | 2 Ridge                                  | Ly AVE                      | eardiac or re | napo L<br>espiratory a | rrest, shoc              | k, or heart             | Approxim                                | ate Interval       |
| Physician 'Medical   |                | <ol> <li>Part I. Enter the disease,<br/>failure. List only one cause</li> </ol> | se on each line.                          |  |                                 |  |                             |               |                        |                          |                         | Between                                 | Onset and<br>leath |
| .aminer  | ĺ              | Immediate Cause (Final disea or condition resulting in death                    |   | ications                                   |                                 | ronic al                                 | conol                       | abuse         | e                      |                          |                         |   |                    |
|  | - 1            |   | b.  | a consequence                              | 217.                            |  |                             |               |                        |                          |                         |   |                    |
|  | ē              | Sequentially list conditions, if any, leading to immediate                      |   | s a consequence                            | of):                            |  |                             |               |                        |                          |                         |   |                    |
|  | Examine        | cause. Enter Underlying Cause (Disease or injury that initiated                 | Due to /or /                              | as a consequence                           | of):                            |  |                             |               |                        |                          |                         |   |                    |
| ted<br>d<br>ansit  | Ĕ              | events resulting in death) Las  | d.  |  |                                 |  |                             |               |                        |                          |                         |   |                    |
| 760,<br>icate be executed<br>physician and<br>the burial - transit   | Medical        | X UNPENDED  | AMENDE                                    | a,27,per                                   | ME.288                          | 1 7/11/0                                 | 8 TT                        |               |                        |                          |                         |   |                    |
| '60,<br>ate be   | Mec            | IF FEMALE:  | 23c, If y                                 | es, outcome of pre                         | anancy                          |  |                             |               | ~                      |                          | I. Date of de<br>Month  | elivery<br>Day                          | Year               |
| 687<br>ertific<br>ding p   |                | 23b. Was decedent pregnant in<br>past 12 months?                                |   | ve birth<br>regnant at time of o           |                                 | Fetal death Other (Specify)              | 3 Ectop                     | oregnan       | cy                     |                          | Monun                   | Duy                                     |                    |
| Box 68760, edeath certificate be the attending physical for use as the but   | Physician      | 1 Yes 2 No 9 🗸  | 11-lu-eur                                 | nknown                                     | 5                               | Other (Specify)                          |                             |               |                        |                          |                         |   |                    |
| or the d   |                | Part II. Other significant con  | ditions contribution                      | ng to death but not                        | resulting in th                 | ne underlying cau                        | se given in F               | Part I.       |                        |                          |                         | ute to the cause                        | _                  |
| , P.O. res that the signed by be detac   | d by           |   |   |  |                                 |  |                             |               |                        |                          |                         | Probably 4                              |                    |
| ords, w requir s been s should   | ete            |   |   |  |                                 |  |                             |               |                        | topsy                    | pri                     | ere autopsy findi<br>ior to completion  |                    |
| e law<br>e has<br>ge 2 sl  | Completed      |   |   |  |                                 |  |                             |               |                        | rformed?<br>s 2 N        |                         | eath? Yes 2                             | 2 No               |
| Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial—transi | ပိ             | 25. Was case referred to med  | tical                                     |  |                                 | 26.F                                     | lace of Deat                | h (Check o    | nly one)               |                          |                         |   |                    |
| /ita   | o Be           | examiner?<br>1 ✓ Yes 2 No   | Hospital: 1                               | Inpatient 2                                | ER/Outpat                       | ient 3 DOA                               | Other <sub>4</sub>          |               | Home 5                 |                          |                         | Other: Scene                            |                    |
| of \ing Phy  | 7: To          | 27. Manner of Death   | 28a. [                                    | Date of Injury<br>Month, Day, Year)        | 28b. Time                       | v,,                                      | Injury at Wo                | _ 1           | 28d. Descril           | oe how inju              | ury occurre             | d                                       |                    |
| On<br>tendir<br>eath.<br>or: A   | tio            |   | Pending nvestigation                      |  |                                 |  | Yes 2                       |               |                        | 101                      |                         | r or Rural Route                        | Number City        |
| ViSI<br>or Att<br>fter d<br>Direct<br>in by  | ific           | 3 Suicide 6 0   | Could not be 28e.                         | Place of Injury - At                       | home, farm,                     | street, factory, off                     | ice building,               | etc.          |                        | n (Street a<br>n, State) | TUG MUNDE               | O Rulai Route                           | Number, Ony        |
| Di<br>pital<br>ours a<br>neral I   | Certification: | 4 Homicide  | determined (Spe                           |  |                                 |  |                             |               | dura de de o o         | auaa(a) ar               | nd manner               | as stated                               |                    |
| Division of Norther Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral   |                | 29a. Certifier (Check only one) Certifyin Medical                               | g Physician: To the<br>Examiner: On the b | e best of my knowle<br>asis of examination | edge, death o<br>n and/or inves | ccurred at the tim<br>tigation, in my op | e, date and<br>inion, death | occurred at   | t the time, d          | ate and pla              | ace, and du             | ue to the cause(s                       | )                  |
| To the within To the comp  | Medical        | 29b. Signature and title of ce  | and man                                   | ner stated.                                |                                 |  | cense numb                  |               |                        | 29d.                     | Date sign€              | ed (Month, Day, )                       | /ear)              |
|  | 2              | 235. Signature and title of ce  | 1   | 1/   |                                 | c  | .C.M.E.                     |               |                        | Ма                       | y 16, 20                | 08                                      |                    |
|  |                | 30. Name and address of pe  | rson who completed                        | cause of death (It                         | em 23a)                         |  |                             |               |                        |                          |                         |   |                    |
| DOLL   |                | Jack Titus MD.  | Deputy Chief M                            | ledical Examir                             | ner 111                         | Penn Street,                             | Baltimore                   | e, MD 21      | 201                    |                          |                         |   |                    |
| S  | ta <u>te</u>   | 31. Date filed (Month, Day, Y   |   | 2. Pogistrar's Sign                        | ature                           | 1 .                                      |                             |               |                        |                          |                         |   |                    |
| Regis  |                |   | 2 3 2008                                  | Dietres                                    | N. A                            | menter                                   |                             |               |                        |                          |                         |   |                    |
| DHMH 17 Rev 1/3  | 2001           |   |   |  | ORIG                            | NAL                                      |                             |               |                        |                          |                         | OCME                                    |                    |

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 0512AM Harold Jav /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cntr. Cheverly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug . 3 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7, Age (In yrs. last birthday) **Funeral** Days Hours New York 1964 **№** 2 □ F Director 081-48-7477 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If team 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventhant must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 ☐ Yes 2 ☑ No Waldorf Charles MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U. S. A. 20603 6181 Red Fox Place Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2€No Specify. 2 Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Tech.Spec1st. Fed.Railroad Assoc. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edward Tritt Miriam Phyllis Simon ဥ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria J. Tritt/Spouse 6181 Red Fox Place Waldorf, MD 20603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem.Grdns, 24,2008 Waldorf, Maryland 22. Name and Address of Facility Raymond Funl. Service, P.A. 21. Signature of Funeral Service Licenses 5635 Washington Ave., La Plata, MD 20646 M00641 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** meumonio /Medical Due to (or as a consequence of): Examiner SEPSI Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, or Attending Physician: The law requires 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: A pletely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature anontity 29c. License number 0055720 address of person who completed cause of death (Item 23a) (Type, Print) enn MA 3001 HOSPDR 31. Date filed (Month, Day, Year) MAY 2 9 2008 \$2. Registrar's Signature State Registrar

|  | _                 | State Registrar   | ite of Maryland /   |                      | rtment of He<br>tificate of D                                    |  | lental Hyg<br>r                 | giene<br>Reg. No. 2          | 808   | 1747  |
|--|-------------------|---|---|----------------------|--|--|---------------------------------|------------------------------|---|---|
| Physicia<br>/Medic   |                   | 1. Decedent's Name (First, Middle, Last)  James Donald Wolfe,   | Sr.   |                      |  |  | 2. Date of Dea<br>May 14,       | 2008                         | Year  | 3. Time of Death<br>9:15 A M                            |
| Examin   | ier               | 4a. Facility Name (If not institution, give street a<br>3511 Russell Thomas L   | ane   |                      | 4b. City, Town, or Davidson                                      |  | 8. Date of Birt                 | Anne                         | y of Death Aruno                                | lel<br>lace (State or Foreign                           |
| Funeral<br>Director  |                   | 5. Social Security Number  220-12-2594  Usual Residence of Decedent   | 7. Age (In yrs. last  | Yrs.                 | Months Days  | Hours Min.   | (Month, Day<br>4/25/19          | y, Year)                     | Mary!   | Land  |
| th the Maryland<br>or 28a-f show<br>e notified at  | Director          | 10a. State 10b. County MD Prince Georg  | ge's Green  |                      | 10f. Zip Code  |  |                                 | 10g. Citizen of              |   | 0d. Inside City Limits 1 ☐ Yes 2 No htry?               |
| permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: I fleen 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.   | by Funeral        | 1 □ Never Married 2 ☑ Married 1 [   | as Decedent Ever in U.S.<br>med Forces?<br>∃Yes 2 □ No<br>Yes, Give<br>par or Dates: 1945-4     |                      | 20770 Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 No          | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No<br>Rican, etc.) | Spec                         | WILL  | etc.<br>te  |
| d within 72 ho<br>giene.<br>er than "natui<br>the Medical  | Completed         | 15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)  | pleted)<br>ollege (1-4or 5+)  | (Give                | lent's Usual Occupa<br>kind of work done o<br>OO NOT use retired | luring most of work<br>)                             |                                 | Public                       | Schoo   | ge's Count<br>ol System                                 |
| ould be file<br>Mental Hy<br>arked othe<br>atic event,   | To Be C           | 17. Father's Name (First, Middle, Last) James N. Wolfe  |   |                      |  | 18. Mother's Nam<br>Elsie SI                         | mith                            |                              |   | Codel   |
| 1 and 2 sho<br>Health and<br>em 27 Is m  |                   | 19a. Informant's Name/Relationship (Type. Pr<br>Mary Lou Wolfe / Wif<br>20a. Method of Disposition  | e 20h Plac  | 7 Gre                | g Address (Street and Penway Plusition (Name of                  | . Green  | nbelt, N                        |                              | 70  |   |
| permit. Pages 1 ar<br>Department of Hea<br>Important: If item i<br>any Injury or other   |                   | 1 □ Burial 2 □ Seremation 3 □ Remov<br>4 □ Donation 5 □ Other (Specify)  21. Signature of Euneral Service Licensee  | ral from State Metr   | opol<br>emato        | natory or other plac<br>itan<br>ry                               | 200  | 8                               | Alexan                       |   | VA  |
| permit. Depart Imports any Inj   |                   | 21. Signature of Funeral Service Licensee  22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy. Bowie, MD 2071  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, |   |                      |  |  |                                 |                              |   |   |
| Physician / Medical Examiner physician and physician and the prival-fransit the prival-fransit physician site of the physician and physician and physician and physician are provided by the physician and physician are provided by the physician and physician are provided by the physician are provided by the physician and physician are provided by the physician are p | ical Examiner     | Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d  | ue to or a la chise uer  Due to (or as a consequer  Due to (or as a consequer                   | nce of):             | Canc   | lv   |                                 |                              |   | Onset and Death   |
| death certific<br>e attending p<br>d for use as  | Physician/Medical | in the past 12 months?  | yes, outcome pf pregnanc<br>□Live birth 2 □ Fetal d<br>□□ Pregnant at time of dea<br>□□ Unknown | eath 3               | □Ectopic pregnancy □ Other (specify) _                           | /  |                                 |                              | Date of deliv                                   | rery<br>Day Year  |
| requires that the<br>een signed by the<br>hould be detache   | by                | Part II. Other significant conditions contribu  | ting to death but not resulti   | ng in the u          | nderlying cause giv  | en in Part I.  |                                 | tobacco use co<br>Yes 2 □ No |   | the cause of death?                                     |
| The law<br>ate has b<br>page 2 sl  | Completed         |   |   |                      |  |  | perf<br>1∐ Yes                  | opsy<br>ormed2<br>2D No      | b. Were aut<br>prior to co<br>death?<br>1 □ Yes | opsy findings availab<br>ompletion of cause o<br>2 □ No |
| Physician: The this certificate ral director, pag  | To Be             | 25. Was case referred to medical examiner?  1 Yes 2 No Hospi  | ital:<br>1  | R/Outpatie           |  |  | lome 5□Res                      | sidence 6XX                  |   | inSon's Hon   |
| ding<br>After<br>fune  |                   | 1 Natural 5 ☐ Pending investigation   | (Month, Day Year)   | 8b. Time o<br>Injury | M 1  | ryat<br>rk?<br> Yes 2∐No                             |                                 | how injury occ               |   | - Davida Number   |
| To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune   | Certification:    | 4 ☐ Homicide determined   | Se. Place of injury - At hom building, etc. (Specify)  n: To the best of my knowl               |                      |  | me date and place                                    | City or To                      | own, State)                  |   | ral Route Number,                                       |
| the Hospital<br>hin 24 hours of<br>the Funeral<br>hpletely filled  | Medical           | (Check only 2 Medical Examiner:   | On the basis of examination and manner stated.  | on and/or i          | nvestigation, in my  | opinion, death occ                                   | urred at the time               | e, date and pla              | ce, and due                                     | to the cause(s)   |
| To the Comp  | M                 | 29b. Signature and title of Pertificial   |   |                      |  | S & & /  |                                 | 29d. Date sig                | 08  |   |
| 2(4)+1   |                   | 30. Name and address of person who comple   | hreenbe   | 1+                   | Print)   | 20770  | , Delse                         | ort m                        | 1010/   | SIMD  |
| S<br>Regis   | tate<br>trar      | 31. Date filed (Month, Day, Year) MAY 1 5 2008  | 32. Registrar's Signatu   | B.                   |  |  |                                 |                              |   |   |

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                     |  |                   | = State<br>RegistraMEND#14perFH5-16-08,BMV,MoCo  |   | tificate of Deat   | th              | R                                   | Reg. No. 200                             | 8 17472   |
|---------------------|--|-------------------|--|---|--|-----------------|-------------------------------------|--|---|
|                     | Physicia   | an                | Decedent's Name (First, Middle, Last)     Chiung Tao Wang  | Wu                                      |  | 2               | 2. Date of Dea<br>Month<br>May      | Day Yes 10, 20                           | ar 3. Time of Death   |
|                     | /Medic<br>Examin   |                   | 4a. Facility Name (If not institution, give street and number)   | wu                                      | 4b. City, Town, or Location  | on of Death     | Hay                                 | 4c. County of De                         |   |
| 100                 |  |                   | Shady Grove Adventist Hospita  | a1                                      | Rockville  |                 |                                     | Montge                                   | omery   |
|                     | Funeral  |                   | 5. Social Security Number 6. Sex 7. Age (In yr.  | s. last birthday)                       | If Under 1 Year If Und<br>Months Days Hours  | rs Min.         | B. Date of Birth<br>(Month, Day     | , Year)                                  | Birthplace (State or Foreign Country)   |
| 4                   | Director   |                   | 219-77-3259 The state of December 1  | 76 Yrs.                                 |  |                 | April 2                             | 21, 1932                                 | Taiwan  |
|                     | land<br>bw   |                   |  | City, Town or Lo                        | cation   |                 |                                     |  | 10d. Inside City Limits   |
|                     | Mary<br>Fied a   | tor               | Maryland Montgomery Ge   | ermantow                                | m  |                 |                                     |  | 1 ☐ Yes 2X No   |
|                     | th the or 282 e noti   | Director          | 10e. Street and Number   |   | 10f. Zip Code  |                 |                                     | 10g. Citizen of What                     | Country?  |
|                     | 23a cust b   | ral               | 20812 Severndale Terrace   |   | 20876  |                 |                                     | Taiwan                                   |   |
| 36                  | permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.  | by Funeral        | 11. Marital Status  1 □ Never Married 2 □ Married  3 ▼Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ▼ No If Yes, Give Year or Dates:   |   | Was Decedent of Hispanic<br>f Yes, specify Cuban, Mexi<br>I ☐ Yes 2█ No <i>Sp</i> ec |                 | ify Yes or No-<br>ican, etc.)       | Black, W                                 | ian   |
| Maryland 21215-0036 | '2 hou   | ted               | 15. Decedent's Education<br>(Specify only highest grade completed)   | 16a. Deced                              | lent's Usual Occupation  | noet of working | Ţ                                   | 16b. Kind of Busine                      | ss/Industry   |
| 2                   | ithin 7<br>ie.<br>i. Med   | Completed         | Elementary/Secondary (0-12) College (1-4or 5+)   |   | kind of work done during m<br>DO NOT use retired)                                    | nost or working | ,                                   | . 1.                                     |   |
| 2                   | led wi   |                   | 12<br>17. Father's Name (First, Middle, Last)  | Та                                      | ilor   | othor's Nama /  | Eiret Middle                        | Seli e                                   | employed  |
| and                 | I be fi<br>ntal F<br>ed ot   | Be                | Unknown  |   |  | Unknow          |                                     | maiden damame)                           |   |
| Ĕ                   | should<br>nd Me<br>mark<br>matic   | 2                 | 19a. Informant's Name/Relationship (Type. Print)   | 19b. Mailin                             | g Address (Street and Nur  |                 |                                     | er, City or Town, State                  | e, Zip Code)  |
| <u>≅</u>            | nd 2 s<br>ulth ar<br>27 ls<br>rtrau  |                   | Chayun Wang / Son  | 20812                                   | Severndale   | Terrace         | e. Germ                             | mantown. M                               | D 20876   |
| ē,                  | s 1 a  |                   | 20a. Method of Disposition 20b   |   | sition (Name of natory or other place)   | Da              |                                     | 20c. Location - City                     |   |
| E                   | Page<br>nent c   | ٠,                | 1 Burial 2 Decremation 3 Hemoval from State  |   | oln Cremator   | y 5/16          | /2008                               | Brentwoo                                 | od, MD  |
| Baltimore,          | permit. Departr Importa any in[s   | (c. )             | 21. Signature of Funeral Service Licensee  |   | Name and Address of Fa   |                 | mple T                              |  | 20852   |
| 68760,              | Climate be executed /Medical Examiner as the burial-transit as the | al Examiner       | 23a. Part1. Er ar the disease, or complications that caused the deshock, c heart failure. List only one cause is each line.  Immediate C we e (Final disease or condition resulting in death)  Sautentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consideration of the condition of t | equence of):                            | er the mode of dying, juch   | a cardiac or    | respirato                           | CTUN<br>UNC                              | Approximate Interval Betwee Orbet and Dea                                     |
| .O. Box             | The law requires that the death certificate to has been signed by the attending physbage 2 should be detached for use as the   | Physician/Medical | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  d.  23c. If yes, outcome pf pred 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of  | etal death 3                            | Ectopic pregnancy  |                 |                                     | 23d. Date of<br>Month                    | delivery<br>Day Year  |
| rds, P.             | quires tha<br>n signed<br>uld be def   | by                | Part II. Other significant conditions contributing to death but not r  | esulting in the u                       | nderlying cause given in Pa  | art I.          |                                     | obacco use contribut<br>Yes 2□No 3□      | e to the cause of death?  Probably 4 Unknown                                  |
| or Vital Records,   | The law recate has been page 2 sho   | Completed         |  |   |  |                 | 24a. Was<br>autop<br>perto<br>1 Yes | rmed7 deat                               | e autopsy findings available<br>to completion of cause of<br>h?<br>Yes 2 ☐ No |
| Vit.                | iclan<br>certifi<br>ector  | Be                | 25. Was case referred to medical examiner?   |   | Other  | lace of Death   |                                     |  |   |
| on or               | To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.  | tion: To          | 27. Manper of Teath  1 Natural 5 Pending 2 Accident Accident 1 Inpatient 2  28a. Date of Injury (Month, Day Year,  | XER/Outpatier<br>28b. Time of<br>Injury | K OLIDON 4L  | 28              |                                     | dence 6 □Other (S<br>how injury occurred | specify)  |
| Division            | al or Atter<br>s after dea<br>al Director<br>ed in by the  | Certification:    | 3 Suicide 6 Could not be determined 28e. Place of injury - Al building, etc. (Spe  | t home, farm, str<br>ecify)             | eet, factory, office   | 28              | 8f. Location (S<br>City or Tox      |  | r Rural Route Number,   |
|                     | ne Hospit<br>n 24 hour.<br>ne Funera   | Medical (         | 29a. Certifier (Check only one) Certifying Physician: To the best of my leading the desired form the basis of examiner: On the basis of examiner and manner stated.  |   |  |                 |                                     |  |   |
| )                   | To th withir comp  | Me                | 29b. Signature and title of certifier  | 7 M                                     | 29c. License numb  | 326             | / /                                 | 29d. Date signed (M                      | onth, Day, Year)  |
|                     |  |                   | 30. Name and address of person who completed cause of death (builliam R. Dooley, M.D. 990)   |   | Print)<br>11 Center Dri  | ive Po          | ckvi11                              | /<br>a. MD 208                           | 50  |
| ľ                   | Sta<br>Regist  |                   | 31. Date filed (Month, Day, Year) 32. Registrar's Sign MAY 1 4 2003  |   | Acarte 8   | 110             | CKVIII                              | <u> </u>                                 |   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 1428 W 11 08 Marie Willey /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Salisbury 26999 Mcleyland Terrace If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days Hours 4/23/1933 1 □ M 2 🕱 F 75 Pennsylvania 222-18-5173 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show ral", or items 23a or 28a-f shov Examiner must be notified at 1 ☐ Yes 2 No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21801 USA items 23a 26999 Mcleyland Terrace Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other traumatic event, the Medical s 1 and 2 should be filed within of Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DP & L 12 engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Star John Sullivan 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1810 W. Clearlake Dr., Salisbury, MD 21804 Dawn Tilghman/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or otl 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 5/14/08 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory <sup>22</sup> Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licentee COL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCUD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 □ Ectopic pregnancy Month Year Day 5 ☐ Other (specify) ed by the a detached for 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No has 1□ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 DOA 1 Yes 2□ No 1 Inpatient 2 □ ER/Outpatient P 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death Certification: (Month, Day Year) Injury 5 ☐ Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title 450497 2/13/08 H50497 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of pe Salisky 100 Ecanoll St hris Smyder

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

MAY 1 4 2008

32 Registrar's Signature

Registrar

MAY

5

|  |                      | 1                    | For State Registrar  | ate of Maryla  |                                       | partment of H<br>Certificate of D   |  |  | ene<br>g. No. 20(                              | 18 17475  |
|--|----------------------|----------------------|--|--|---------------------------------------|---|--|--|--|---|
|  | sicia<br>edica       | n                    | 1. Decedent's Name (First, Middle, Last)   | ARD  |                                       |   |  | 2. Date of Death<br>Month<br>MAY 1           | Day Yea 2008                                   | 3. Time of Death 2:15 P M   |
|  | mine                 | r                    | 4a. Facility Name (If not institution, give street  602 Taney Ave.  5. Social Security Number  193-24-7351  6. Sex 1 □ M 2   | 7. Age (In y   | rs. last birthd<br>Yrs                | Months Days   |  | 8. Date of Birth (Month, Day, May 2, 1       | 4c. County of De<br>Freder:<br>9. E<br>932 Per |   |
| ъ  |                      |                      | Usual Residence of Decedent  10a. State  10b. County  Maryland  FRederick  |  | City, Town or                         |   |  |  |  | 10d. Inside City Limits  ★☆Yes 2☐ No  |
| h with the   | at be notifi         | o ire                | 10e. Street and Number 602 Taney Avenue  | 1,22   |                                       | 10f. Zip Code<br>21702  |  | 10   | g. Citizen of What                             | Country?  |
| re, Maryland 21215-UU36 It and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hyglene. It marked other than "natural", or items 23a or 28a-f show | Mariner ma           | ≥∣                   | 1 Never Married 2 Married 1  | as Decedent Ever in<br>med Forces?<br>□Yes 2↓□No<br>Yes, Give<br>ear or Dates: | U.S. 1                                | 13. Was Decedent of Hill If Yes, specify Cubar 1 ☐ Yes 2 🛣 No                           | spanic Origin? (Sp<br>n, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)             | 14. Race - Al<br>Black, Wi<br>Specify:         | merican Indian,<br>hite, etc.<br>White  |
| d 21215-UU36 filed within 72 hours aff Hyglene. ther than "natural", or  | ne medical t         | Completed            | 15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)   | pleted)<br>bllege (1-4or 5+)   | — (G                                  | ecedent's Usual Occupa<br>Give kind of work done d<br>fe. DO NOT use retired,<br>emaker | ation<br>during most of work<br>)                    | ing 1  | 6b. Kind of Busine                             |   |
| aryland 2<br>should be filed and Mental Hygic<br>marked other  | tic event, I         | To Be Co             | 17. Father's Name (First, Middle, Last) Levi J. Kelly  |  | 1                                     |   | 18. Mother's Name<br>Mary Gr                         |  | aiden Surname)                                 |   |
| 'e, Maryla 1 and 2 should Health and Mer   | her trauma           |                      | 19a. Informant's Name/Relationship (Type. Pacarol M. Ward-Morris-  | Daughter   | 1094                                  | lailing Address (Street a   | ert Troor  | Lane, S                                      | Scottsdal                                      | e, Arizona  |
| Baltimore, permit. Pages 1 ar Department of Hee Important: If item   | jury or oth          |                      | 20a. Method of Disposition  1 ☐ Burial 2X☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)   | al from State  | b. Place of Di<br>cemetery,<br>auffer | isposition (Name of crematory or other place Crematory                                  | 5/15   | /2008 Fr                                     |  | Maryland  |
| Depariment   | any in               |                      | 21. Significant of Funeral Service Kipénsee  23. Part 1. Enter the disease, or complication  | e Ol   | ine                                   |   | umtown Pi  | lke, Fred                                    |  | aryland 21702   |
| Physic<br>/Medi  | cal                  |                      | shock, or heart failure. List only one car<br>Immediate Cause (Final<br>disease or condition<br>resulting in death)  | use on each line.  | endin                                 | 1 ischem  | lea  | or respiratory arre                          |  | Interval Between Onset and Death  |
| icate be executed physician and  | e burial-transit     | dical Examiner       | if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | Due to (or as a cons   |                                       |   |  |  |  | Wichital .  |
| the death certify the attending  | Iched for use as the | Physician/Medic      | in the past 12 months?   | yes, outcome of pre □ Live birth 2□ F □ Pregnant at time □ Unknown             | etal death                            | 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _   | у  |  | 23d. Date of<br>Month                          | delivery<br>Day Year  |
| ecords, P. law requires that as been signed b  | uld be deta          | <u>م</u>             | Part II. Other significant conditions contribu   | ting to death but not  | resulting in th                       | ne underlying cause give  | en in Part I.  |  |  | e to the cause of death?  Probably 4 Honknown                                 |
| I Ke<br>The lar<br>ate has   | page 2               | e Completed          | 25. Was case referred to medical   |  |                                       |   | 26 Place of Dani                                     | 24a. Was ar<br>autops<br>perforn<br>1  Yes 2 | y prior<br>deat<br>2 No 1 1                    | e autopsy findings available<br>to completion of cause of<br>h?<br>Yes 2 □ No |
| on of<br>ding Phys   | tuneral dire         | Certification: To Be | examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation  | a. Date of Injury<br>(Month, Day, Year   | r) 28b. Tin<br>Inju                   | iry Work  | er: 4 🗆 Nursing He                                   | ome 5 ☑ Reside<br>28d. Describe ho           | ince 6 Other (see injury occurred              | Specify)<br>or Rural Route Number,  |
| DIVISION To the Hospital or Attentivition 24 hours after death To the Funeral Director:  |                      | Medical Cer          | 29a. Certifier Check only (Check only Medical Examiner:  | n: To the best of my<br>On the basis of exam                                   | knowledge,                            | death occurred at the tir   | me, date and place<br>opinion, death occu            | , and due to the corred at the time, do      | ause(s) and manne<br>ate and place, and        | er as stated.<br>due to the cause(s)  |
| To the within 2 To the   | comple               | Med                  | 29b. Stagatule and title of certifier  | CAZI   | MD                                    | 29c. Licens   | e number<br>{ 4 1 6 4                                | 2  | 9d. Date signed (M                             | lonth, Day Year)  |
| 8  |                      |                      | 30. Name and address of person who completed to the state of the state | Chuson   | Item 23a) (Ty                         | ( Print) f  | reduie   | h HO   | 21702  | -08<br>2 A-Z- HEGA.   |
| Re   | Stat<br>gistra       |                      | 31. Date filed (Month, Day, Year)  MAY 1 5 2   | 32. Registra's Si  | and the                               | 4 Aprile  |  |  |  |   |

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

|                         |  |                  | For State Registrar  | State of Marylar  |                                   | tificate of L   |  | Reg  | No. 2008                                    | 17476   |
|-------------------------|--|------------------|--|---|-----------------------------------|---|--|--|---|---|
|                         | Physici  |                  | 1. Decedent's Name (First, Middle, Last)  Dorothy P. Willia  | ms  |                                   |   |  | 2. Date of Death<br>Month<br>May 22,           | Day Year 2008                               | 3. Time of Death<br>8:30 p.π <sup>M</sup> .         |
|                         | /Medio   |                  | 4a. Facility Name (If not institution, give str<br>WHS Frostburg Nursir  |   | er                                | 4b. City, Town, or<br>Frostbur  | Location of Death                                  |  | 4c. County of Dear<br>Allegany              | th  |
|                         | Funeral<br>Director  |                  | 213-20-0021  | 7. Age (In yrs. 81  | last birthday)<br>Yrs.            | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                     | 8. Date of Birth<br>(Month, Day, Y<br>9/01/26  | (ear) 9. Bird<br>Co<br>MD                   | hplace (State or Foreign<br>buntry)<br>)            |
|                         | e Maryland<br>3a-f show<br>tified at   | ctor             | Usual Residence of Decedent  10a. State 10b. County  WV Mineral  |   | ty, Town or Lo                    |   |  |  |   | 10d. Inside City Limits 1                           |
|                         | h with th<br>23a or 24<br>st be no   | Funeral Director | Rt. 5, Box 138   |   |                                   | 10f. Zip Code<br>26726  |  | 10g  | U.S.A.                                      | ountry?   |
| 920                     | should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Medical Examiner must be notified at  |                  | 11. Marital Status  1  Never Married 2 Married  3 Nover Married 2 Divorced   | . Was Decedent Ever in U<br>Armed Forces?<br>1 ☐ Yes 2 X No<br>If Yes, Give<br>Year or Dates: |                                   | Was Decedent of Hi<br>f Yes, specify Cube<br>I ☐ Yes 2X No              | ispanic Origin? (Spen, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)               | 14. Race - Ame<br>Black, Whit               |   |
| Maryland 21215-0036     | within 72 ho<br>sne.<br>than "natur<br>te Medical  | Completed by     | 15. Decedent's Educa<br>(Specify only highest grade of<br>Elementary/Secondary (0-12)<br>12th  | tion<br>completed)<br>College (1-4or 5+)  | (Give<br>life. L                  | lent's Usual Occup:<br>kind of work done o<br>DO NOT use retired<br>1es | during most of worki                               | ing  | Sb. Kind of Business<br>Real Estat          |   |
| nd 2                    | e filed val Hygie<br>I other t<br>vent, th   | Be Co            | 17. Father's Name (First, Middle, Last)  |   | J                                 | 103   | 18. Mother's Name                                  | (First, Middle, Ma                             |   |   |
| <u> </u>                | should b<br>and Ment<br>marked<br>umatic e   | To E             | Arthur T. Poland   | Dulan   | 40h Mailine                       | and Address (Otrost   | Elizabet   |  | 3'4   | Tio Corda)  |
| ā<br>Z                  | nd 2 shoulth and 27 Is mi  |                  | 19a. Informant's Name/Relationship (Type<br>George Williams/son  | . Print)  |                                   | •   | 88, Keysei   |  | City or Town, State, 2<br>126               | Zip Code)   |
| Baltimore,              | permit. Pages 1 and 2 should<br>Department of Health and Men<br>Important: If item 27 is marke<br>any injury or other traumatic.   |                  | 20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Rer  4 ☐ Donation 5 ☐ Other (Specify)   |   | Place of Dispo                    | sition (Name of<br>matory or other place<br>emetery                     | , ,  | Date 20  | oc. Location - City or<br>esternport        |   |
| Balti                   | permit. Page<br>Department<br>Important: If<br>any Injury or<br>once.  |                  | 21. Signature of Funeral Service Licensee  | nopunge   | M                                 | Name and Address  | imoral U   | ome, Inc.                                      | 726   |   |
|                         | Physician<br>/Medical<br>Examiner  |                  | 23a. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)          | tions that caused the deacause on each line.  Res Planto  Due to (or as a consect  Lintractab | or of the                         | alme  | g, such as cardiac o                               |  |   | Approximate Interval Between Onset and Death IS duy |
| ,                       | tificate be executed<br>g physician and<br>as the burial-transit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | Due to (or as a consec  | quence of):                       |   | · .  |  |   | <i>y</i>  |
| 68760,                  | cate be e<br>physiciar<br>the buri   | ledical E        | <b>€</b> d.  |   |                                   |   |  |  |   |   |
|                         | = 0,0  | by Physician/Me  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  | t. If yes, outcome pf pregn<br>1□Live birth 2□Fet<br>4□Pregnant at time of<br>9□Unknown       | al death 3□                       | Ectopic pregnancy Other (specify)                                       | •  |  | 23d. Date of de<br>Month                    | livery<br>Day Year                                  |
| ds, P.                  | luires that<br>signed by<br>lid be deta  | d by Ph          | Part II. Other significant conditions control  | ibuting to death but not res  | sulting in the ur                 | nderlying cause give  | en in Part I.                                      |  |   | o the cause of death?                               |
| Vital Records, P.O. Box | To the Hospital or Attending Physician: The law requires that the death cer within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use  | Completed        |  |   |                                   |   |  | 24a. Was an<br>autopsy<br>performe<br>1  Yes 2 | prior to                                    | utopsy findings available completion of cause of    |
| <u> </u>                | /sician<br>s certifi   | o Be             | 25. Was case referred to medical examiner?  1 Yes 2 No   | spital: 1 ☐ Inpatient 2 ☐   | ER/Outpatien                      | t 3 DOA Othe  |  | n <i>(Check only one)</i><br>me 5 □ Besiden    | ce 6 □Other (Spe                            | acify)  |
| Division or             | nding Phy<br>uth.<br>r: After this<br>e funeral c  | ation: To        | 27. Manner of Death  1 Natural 5 Pending investigation   | 28a. Date of Injury<br>(Month, Day Year)  | 28b. Time of<br>Injury            | 28c. Injur<br>Worl  |  | 28d. Describe how                              |   | city  |
| Divis                   | al or Atte<br>s after des<br>al Directo<br>ed in by th   | Certification:   | 3 ☐ Suicide 6 ☐ Could not be<br>4 ☐ Homicide determined  | 28e. Place of injury - At h<br>building, etc. (Special  |                                   | eet, factory, office  |  | 28f. Location (Stre<br>City or Town,           | et and Number or R<br>State)                | ural Route Number,                                  |
|                         | To the Hospital or Attenwithin 24 hours after death To the Funeral Director:   | Medical (        | 29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine  | cian: To the best of my kn<br>r: On the basis of examin<br>and manner stated.                 | owledge, death<br>ation and/or in | n occurred at the tir<br>vestigation, in my o                           | me, date and place,<br>ppinion, death occur        | and due to the cau<br>red at the time, dat     | use(s) and manner a<br>te and place, and du | s stated.<br>e to the cause(s)                      |
|                         | To the To the Company of the Company | Me               | 29b. Signature and title of certifier  Womock S  | hi MD   |                                   | 29c. Licenson   | 55325  |  | 1. Date signed (Mon                         | th, Day, Year) 23, 2008                             |
|                         |  |                  | 30. Name and address of person who com   | MI) 925   | BISHO                             | P WALST   | I RD CI  | LHBERLAN                                       | D MD 2                                      |   |
|                         | Sta<br>Registi   |                  | 31. Date filed (Month, Day, Year)  | 32. Registrar's Sign  | Local                             | 1   |  |  |   |   |

DHMH 17 Rev 1/2001

Armiger, Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year 1:15P M 28 4/ice /Medical 08 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charlestown Care Renaissance Garden Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 08/19/1917 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex **Funeral** Days 1□M 2**∑**F 215-34-1557 91 Director North Carolina Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 □Yes 2XINo Director MD Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 719 Maiden Choice Lane HR331 21228 United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 2 Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) d 2 should be filed w th and Mental Hygier 7 is marked other th Registered Nurse Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arvil Sugg ٩ Emma Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2:
Department of Health as
Important: If item 27 is
any injury or other trau Mrs. Linda Sue Hodges (Daughter) 5217 Chicora Court, Jacksonville, FL. 32258 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Woodlawn Cemetery 06/04/2008 Baltimore, Maryland Danation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. Tignatu of Funeral Service 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Myocardial disease or condition resulting in death) /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) as the burial-transi Exami Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE: nse 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed per tension 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate 1∐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: To the Hospital or Attending 1 ⊡Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated.

State Registrar 29b. Signature and title of certifie

Deneen Bowlin 31. Date filed (Month, Day, Year)

Dent

MAY 3 0 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ma

Baltimore,

Box 68760,

P.0.

Records,

or Vital

Division

mos

711 Maiden

32. Registrar's Signature

29c. License number

21228

|          |  |                  | For St<br>State<br>Registrar  | ate of Maryland / De<br><i>C</i> i                                     | partment of H<br>ertificate of L                     | ealth and M<br>D <i>eath</i>               | lental Hygie<br>Reg.                        |   | 17480  |
|----------|--|------------------|---|--|--|--|---|---|--|
|          |  |                  | Decedent's Name (First, Middle, Last)   |  |  |  | 2. Date of Death<br>Month                   | Day Year                                | 3. Time of Death                                   |
|          | Physicia<br>/Medic   |                  | Dolores Therese Ak  | er   |  |  | May 15,                                     | 2008                                    | 12:17 PM   |
| e.       | Examin   |                  | 4a. Fecility Name (If not institution, give street  |  | 4b. City, Town, or                                   |  |   | 4c. County of Deat                      |  |
|          |  |                  | 4821 Randolph Road  |  | Rockvi   | I Le If Under 24 Hrs.                      | 8. Date of Birth                            | Montgomer                               | hplace (State or Foreign                           |
|          | Funeral<br>Director  |                  | 5. Social Security Number 6. Sex 1  | 7. Age (In yrs. last birthda<br>78 Yrs.                                | Months Davs  | Hours Min.                                 | Month, Day, Ye May 17, 1                    | ear) Co                                 | ntana  |
|          | pud *  | -                | Usual Residence of Decedent  10a, State 10b, County   | 10c. City, Town or   | Location   |  |   |   | 10d. Inside City Limits                            |
|          | Maryli<br>f •ho  | 5                | MD Montgomery   |  | ville  |  |   |   | 1 ☐ Yes 2√ No                                      |
|          | 28a-   | Funeral Director | 10e. Street and Number  |  | 10f. Zip Code  |  | 10g.  | Citizen of What Co                      | ountry?  |
|          | h with   | O I              | 4821 Randolph Road  |  | 20852  | 2  |   | USA                                     |  |
|          | ems arms   | ner              | 11. Marital Status 12. W  | /as Decedent Ever in U.S. 1 med Forces?                                | 3. Was Decedent of Hi<br>If Yes, specify Cuba        | spanic Origin? (Sp<br>n, Mexican, Puerto   | ecify Yes or No-<br>Rican, etc.)            | 14. Race - Ame<br>Black, White          |  |
| 0000     | filed within 72 hours after death with the Maryland<br>Hygiens.<br>bther than "natural", or items 23s or 28s-f show<br>ent, the Medical Exactinat must be notified at  | by Fu            | 1 Never Married 2 Married 1   | ☐ Yes 2 XX No<br>Yes, Give<br>ear or Dates:                            | 1 ☐ Yes 2 No   | Specify:                                   |   | Specify: wh                             | ite  |
| 5        | 72 ho  | ted              | 15. Decedent's Education<br>(Specify only highest grade con                                   | n 16a. De  | cedent's Usual Occupa                                | ation<br>during most of work               | ina unk 161                                 | b. Kind of Business/                    | Industry   |
| Y        | within 7   | Completed        |   | college (1-4or 5+)   | e. DO NOT use retired,                               | )  |   | ealthcare                               | 2  |
| 7 7      | filed v<br>Hygie<br>ther t   |                  | 17. Father's Name (First, Middle, Last)   | 0  |  | 18. Mother's Nam                           | e (First, Middle, Mai                       | iden Sumame)                            |  |
|          | lid be<br>lental<br>rked c   | To Be            | George Edward Goose   | alaw   |  | Clara The                                  | rese Hans                                   | on                                      |  |
| ם<br>כ   | shou<br>and M<br>mar   |                  | 19a. Informant's Name/Relationship (Type, F   |  | ailing Address (Street a                             |  |   |   | Zip Code)  |
| <u>≥</u> | end 2<br>ealth a<br>m 27 i   |                  | Raymond Aker/spouse   |  | 21 Randol 1  |  |   |   |  |
| Dalimore | permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Month Hygiene. Department of Health and Month Hygiene. Department of the m 27 is marked other than "natural", or items 23a or 28a-1 ehow eny injury or other traumatic event, the Mealical Examinar must be notified at once.  |                  | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☒ Donation 5 ☐ Other (Specify) | val from State   | sposition (Name of<br>crematory or other place       | θ)   | Date 20                                     | c. Location - City or                   | Town, State  |
| Dall     | permit. Departr imports eny inj  |                  | 21. Signature Funeral Trice Licensee Ward   | 1 8 8 9 11 ~   | 22. Name and Addres<br>State Anato<br>Baltimore,     |  |   | altimore                                | Street   |
|          |  |                  | 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car     | ns that caused the death. Do not use on each line.                     | enter the mode of dying                              | g, such as cardiac                         | or respiratory arrest                       | ,                                       | Approximate<br>Interval Between<br>Onset and Death |
| 7        | Physician  |                  | Immediate Cause (Final disease or condition resulting in death)                               | enterstitial lu<br>Due to (or as a consequenca of):<br>Rheumatoid as   | ng clise as  | e  |   |   | Onset and Death                                    |
|          | /Medical<br>Examiner   |                  | resulting in doubl)   | Due to (or as a consequenca of):                                       | H. Lic   |  |   |   |  |
|          |  | ler              | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying            | Due to (or as a consequence of):                                       | 7111113  |  |   |   |  |
|          | cuted<br>nd<br>ransit  | Examiner         | that initiated events   |  |  |  |   |   |  |
| Š.       | icate be executed<br>physicien and<br>s the burial-transit   | EX               | resulting in death) Last  | Due to (or as a consequence of):                                       |  |  |   |   |  |
| 90/00,   | physicate to the control of the cont | dical            | d   |  |  |  |   |   |  |
| XOO      | To the Hospital or Attending Physician: The law requires that the death certif within 24 hours elter death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as   | Physician/Me     | is the past 13 months?  |  | 3 □Ectopic pregnancy                                 |  |   | 23d. Date of de<br>Month                | livery<br>Day Year                                 |
| -<br>-   | the de<br>y the a  | ysic             | 1 Ves 2 Killio  | □Pregnant at time of death □ Unknown                                   | 5 ☐ Other (specify)                                  |  |   |   |  |
| 7        | s that<br>ned b  | by Pr            | Part II. Other significant conditions contribu  | ting to death but not resulting in th                                  | e underlying cause give                              | en in Part I.                              | 23e. Did toba                               | cco use contribute to                   | o the cause of death?                              |
| SDIC     | en sig   | edt              | hypertension  |  |  |  | 1 ☐ Yes                                     | 2 □ No 3 □ P                            | robably 4 Unknown                                  |
| ecol     | law re<br>las be   | Completed        | aterial & (nillation  |  |  |  | 24a. Was an autopsy                         | prior to                                | utopsy findings available completion of cause of   |
| <u>r</u> | : The<br>cete h  | Con              | chinic obstructive  | pulmonary cl   | isease   |  | performe<br>1 □ Yes 2 0                     | d? death?<br>1 ☐ Yes                    | 3/2NO  |
| N E      | sician<br>certifi<br>rector  | Be               | 25. Was case referred to medical examiner?  | tal:   | Othe   | or   | in (Check only one)                         |   |  |
| 5        | Phys<br>arthis<br>eral di  | .: To            | 1 163 5 2 2 2 40  | Ba. Date of Injury 28b. Tim  | e of 28c. Injury                                     | 4 ☐ Nursing H                              | 28d. Describe how                           | injury occurred                         | ecity)   |
|          | ath.<br>ath.<br>or; Afte   | atio             | 1 Natural 5 ☐ Pending 2 ☐ Accidenl investigation  | (Month, Day Year) Inju   |  | K?<br>Yes 2 □No                            |   |   |  |
| DIVISION | or Atte<br>efter de<br>Directo   | ertification;    | 3 Suicide 6 Could not be 4 Homicide determined  | Be. Place of Injury - At home, farm, building, etc. (Specify)          | , street, factory, office                            |  | 28f. Location (Stre<br>City or Town,        | et and Number or R<br>State)            | lural Route Number,                                |
|          | Hospite 4 hours Funeral (ely fille)  | edical C         | (Check only 2 Medical Exeminer:   | n: To the best of my knowledge, d<br>On the basis of examination and/o | eath occurred at the tin<br>r investigation, in my o | ne, date and place,<br>pinion, death occur | and due to the cau<br>red at the time, date | se(s) and manner a<br>and place, and du | s stated.<br>e to the cause(s)                     |
|          | To the within 2 Fo the somple  | Med              | 29b. Sign pury and title of certifier   | and manner stated.   | 29c. License   |  |   | I. Date signed (Mon                     |  |
|          | . •  |                  | Nobert H X  | vare MD  |  | 005552                                     | 2 M   | ay 22,                                  | 2008.  |
|          |  |                  | 30. Name and address of person who comple<br>ROBERT H GERARD                                  | 1500 Folect CI   | pe, Print)   | Silves Sn                                  | ina Mai                                     | soland 2                                | 0910   |
|          | Sta  |                  | 31. Date filed (Month. Dav. Year)   | 1500 Fosest 61   | and a  | 11000                                      | 11  | transfer c                              |  |
|          | Registr  | ar               | MAY 3 0 2008  | plane Is by  |  |  |   |   |  |

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month May 23, Physician 2008 James W. Abshire 4:12 PM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore Timonium If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours 1 ₹ M 2 □ F Director 268-40-4121 Oct 12, 1940 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified as Director 1 ☐ Yes 2√∑ No MD Harford Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 751 Gist Road 21157 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 160-6 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 Widowed 4 ☐ Divorced 60-66 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) chef food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clyde Elmer Abshire Loriane Cohn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilchrist Hospice 555 W. Towsontown Blvd Towson, MD Towson, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 21. Signatur of Euneral Struce License Director 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) TONIUE CANCER, METASTATIC MONTHS /Medical Due to (or so consequence of): Examiner Sequentially list conditions, if any, leading to manage cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s 1 ☐ Yes 2 X No 1 ☐Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPILE 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation nours after death.

neral Director: Af
filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \(\) Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D44395 MAY 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DANIEUE DOBERMAN, MO 6565 NEHARLES ST, SUITE ZOG BALTIMORE, MD 2,204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Nannie Delores Bracey 1:45A M 18, /Medical Mav 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 2475 Perring Manor Road 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 61 Yrs. If Under 1 Year | If Under 24 Hrs. **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1 □ M 2 □ X Min. Director 231-66-9437 1946 Virginia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County r than "natural", or items 23a or 28a-f show the Midical Exeminar most by notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director N/A Maryland Baltimore 1 √ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2475 Perring Manor Road 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black ģ 1 ☐Yes 2X No 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Private Industry Janitorial Services other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any Injury or other traumatic event SIDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Edward Bracey Ella Beatrice smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 1742 Montpellier St Baltimore, Maryland Serina Freeman/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 5/25/08 Town Cemetery South Hill, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home . Signature of Funeral Ser 5240 Reisterstown Road Baltimore, Maryland arri 23a. Part 1. Enter the di ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** METHSTATT GAUBURDA resulting in death) /Medical Due to (or a a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of). burial-Division of Vital Records, P.O. Box 68760, physician Physician/Medical as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has certificate ha autopsy performed 1 ☐ Yes 2 ☑ No 2 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 ☐ 📈 0 this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? After 28d. Describe how injury occurred 1 Natural 5 Pending investigation after death. 1 □Yes 2 □No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho

To the Fune

completely f (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year)

'Registrar

State

30. Name and address of person

31. Date filed (Month, Day, Year)

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2008

MARYLAND

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UNIVERSITY

completed cause of death (Item 23a) (Type, Print)

3 Registrar's Signature

| 08-03996                   |
|----------------------------|
| Priscilla Katherine Bizich |

| State of Maryland | / Depa | artment | of He | alth and | Menta | l Hygien |
|-------------------|--------|---------|-------|----------|-------|----------|

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| 6 | . U | U | U | ŧ | - 1 | 4 | U | 1 |

|  |                  | 1- For State<br>Registrar   |   | C                       | ertific      | ate of                | Death                               | _             |              | Re                             | g. No.        |                    |              | 5 1110                     |
|--|------------------|---|---|-------------------------|--------------|-----------------------|-------------------------------------|---------------|--------------|--------------------------------|---------------|--------------------|--------------|----------------------------|
| Physici<br>Medical Exami   |                  | 1. Decedent's Name (First, Midd   |   |                         |              | Date of Deat<br>Month | h<br>Dav                            | Year          |              | 3. Time of Death               |               |                    |              |                            |
| viedicai Exami   | ner              | Priscilla  4a. Facility Name (if not institution                        | Kathryn                                 | Bizi                    | cn           | 1.                    | 611 T                               |               |              | May 25, 20                     | 008           |                    |              | 0919 hrs                   |
| The same of the sa |                  | 606 Holly Avenue  | on, give street and nu                  | imber)                  |              | 4                     | b. City, Town, or<br>Edgewood       | Location of   | Death .      |                                |               | County of<br>rford | Death        |                            |
| Funeral  |                  | 5. Social Security Number   | 6. Sex                                  | 7. Age (In yn           | s. last birt | hday)                 | If Under 1 Yea                      |               |              | 3. Date of Birt                | h(MM/DE       |                    |              | place (State or            |
| Director   |                  | 217.62.6818   | 1 M 2 F                                 |                         | 54           | Yrs.                  | Months Day                          | s Hours       | Min.         | 12.30.1953 Foreign Country) MD |               |                    |              | ntry) MD                   |
|  |                  | Usual Residence of Decedent   |   |                         |              |                       |                                     |               |              |                                |               |                    |              |                            |
| w any  |                  | 10a. State 10b. County  |   |                         |              | or Location           | n                                   |               |              |                                |               |                    | 1            | 10d. Inside City Limits    |
| Aaryland<br>28a-f show<br>1 at once.   | tor              | MD Har  | ford                                    | E                       | dgew         | rood                  |                                     |               |              |                                |               |                    |              | 1 Yes 2 No                 |
| with the Maryland<br>ms 23a or 28a-f sho<br>be notified at once.   | irec             | 10e. Street and Number  |   |                         |              | 1                     | 10f. Zip Code                       |               |              | 10g: Citizen of What Coul      |               |                    |              | ry?                        |
| ith the  | 교                | 606 Holly Di  |   |                         |              |                       | 21040                               |               |              |                                |               | .A.                |              |                            |
| ath w<br>items   | Funeral Director | 11. Marital Status 1 Never Married 2 M                                  | 12. Was Dec                             | edent Ever in<br>orces? | ı U.S.       |                       | Decedent of His<br>s, specify Cubar |               |              |                                | 14            | 4. Race<br>White,  |              | an Indian, Black,          |
| ter de<br>", or<br>er mu   |                  | 3 Widowed 4 ⊠Div  | 1 Yes                                   | 2 No                    | )            | 1                     | Yes 2 No                            | specify:      |              |                                | S             | pecify:            | Whi          | .te                        |
| 1215-0036<br>Id be filed within 72 hours after death with the Maryland<br>fental Hygiene.<br>Jarked other than "natural", or items 23a or 28a-f sho<br>event, the Medical Examiner must be notified at once  | Completed by     | 15. Decedent's Education (Spe   | or Dates:                               |                         | 16a.         |                       | s Usual Occupat                     |               | ind of worl  | k done                         |               | d of Busi          | ness/In      | dustry                     |
|  | lete             | Elementary/Secondary (0-12)   | College (1                              | -4 or 5+)               |              | during mo             | st of working life                  | . DO NOT (    | use retired  | )                              |               |                    |              |                            |
| 003<br>Within ene.   | mp               | 12  | 1                                       |                         | C            | ab I                  | river                               |               |              |                                | Tra           | nsp                | ort          | ation                      |
| 15-00<br>filed with<br>Hygiene<br>d other  |                  | 17. Father's Name (First, Middle  |   |                         |              |                       |                                     |               | ,            | irst, Middle, M                |               | ,                  |              |                            |
| 21215-0036 wild be filed within 7 Mental Hygiene. marked other than c event, the Medica  | o Be             | Nicholas E  | Bizich                                  |                         | 1 10         | . Mailina             | Address (Stree                      | Lora          | Lec          | na Pa                          | irks          |                    | <b>C</b> 1 1 |                            |
| Baltimore, MD 2: permit. Pages I and 2 should Department of Health and MI Important: If item 27 is m. injury or other traumanic e.   | Ě                | April Black   |   | h+om                    |              |                       |                                     |               |              |                                |               |                    |              |                            |
| e, N<br>and and Health<br>item   |                  | 20a. Method of Disposition  |   | 20                      | b. Place o   | of Disposit           | Arnclif<br>ion (Name of cer         | metery,       | <u>coad</u>  | Balt                           | 20c. Ló       | MD<br>cation - C   | ity or T     | 1221<br>own, State         |
| ages l   |                  | 1 Burial 2 Cremation  |   |                         | cremat       | ory or othe           | er place)                           |               |              |                                |               |                    |              |                            |
| Baltimore,<br>permit, Pages I ar<br>Department of Hee<br>Important: If ite   | 10               | 4 Donation 5 Other S<br>21. Signature of Funeral Service                |   | 10144                   | 21162        | 22. Na                | ake Cre                             | s of Facility | CARA         | /Stor                          | ReT           | tsv                | 111          | e, MD<br>hrmann,           |
| Dep Imp  |                  | Luca de Suco  | Rott                                    | W199                    | 5            | Ρ.                    | A. 871                              | L7 Gr         | een          | Pasti                          | ires          | Dr                 | ьо<br>В      | alto., MD                  |
| Physician  |                  | 23a. Part . Enter the disease, or failure. List only one cause          | complications that ca                   | aused the dea           | ath. Do no   | ot enter the          | e mode of dying,                    | such as ca    | rdiac or re  | spiratory arre                 | st, shock     | , or hear          |              | Approximate Interval       |
| /Medical<br>\(\sum{xaminer}\)  |                  | Immediate Cause (Final disease  | A 4.1.                                  | sclero                  | tic o        | cardi                 | ovascul.                            | ar di         | sease        | 2                              |               |                    |              | Between Onset and<br>Death |
| Xammer   |                  | or condition resulting in death)  | Due to (or as a                         |                         |              |                       |                                     |               |              |                                |               |                    |              |                            |
|  | 'n               | Sequentially list conditions, if any, leading to immediate              | b<br>Due to (or as a                    | consequence             | a of).       |                       |                                     |               | _            |                                |               |                    |              |                            |
|  | miner            | cause. Enter Underlying Cause<br>(Disease or injury that initiated      |   | CONSCIPCION             | J 01).       |                       |                                     |               |              |                                |               |                    |              |                            |
| nsit ed  | Exa              | events resulting in death) Last   | Due to (or as a                         | consequence             | e of):       |                       | -                                   |               |              |                                |               |                    |              |                            |
| 760, icate be executed physician and the burial - transit  |                  | X UNPENDED  | d.                                      | #232                    | 27 20        | ×ME                   | ~001 0                              | 16 100        | mm           |                                |               |                    |              |                            |
| 8760,<br>tificate be exing physician as the burial a   | n/Medica         | IF FEMALE:  |   | E.G880                  |              | 8 11                  | g882 8                              | /0/00         | T T          |                                | 100.1         |                    |              |                            |
| 38760,<br>rtificate be<br>ing physic<br>as the bur   | and a            | 23b. Was decedent pregnant in the past 12 months?                       | ne 1 Live b                             |                         |              | Feta                  | ıl death 3 [                        | Ectopic       | pregnancy    | ,                              |               | Date of de<br>onth |              | ay Year                    |
| Box 68<br>e death certi<br>the attendin<br>ed for use a  | sici             | 1 Yes 2 No 9 V Un   |   | ant at time of          |              |                       | er (Specify)                        |               |              |                                |               |                    |              |                            |
| the de   | Physicia         | Part II. Other significant condit                                       | 9 Unkno                                 |                         |              | e in the con          | alantida a accordi                  | -i I- D       | 4.1          | OO - Distant                   |               | 1-2                | 1-1-11       | (1, 110                    |
| P.O.   | 百                | . art in other organicality solidar                                     | contributing to                         | death but no            | it resulting | y in the un           | denying cause g                     | given in Far  | ι            |                                |               |                    |              | ne cause of death?         |
| ds,<br>equire<br>een si  | ompleted         |   |   | ·                       |              | ·                     | <del></del>                         |               |              | 24a. Was a                     |               |                    |              | ppsy findings available    |
| COr<br>law r<br>has b  | 흽                |   |   | •                       |              |                       |                                     |               |              | autops<br>perforr              | sy :          | pric               |              | mpletion of cause of       |
| tal Reco   | 0                | OF Management   | . 1                                     |                         |              |                       |                                     |               |              | 1 🗸 Yes 2                      |               |                    | / Yes        | 2 No                       |
| Vital Rec<br>ysician: The I<br>his certificate I   | Be               | 25. Was case referred to medica examiner?                               | Hospital:                               | npatient 2              | - FD/O       | utpatient             |                                     | of Death (0   |              |                                |               |                    |              |                            |
| of Vital Records, ig Physician: The law requir ther this certificate has been a meral director, page 2 should I  | £                | 1 Yes 2 No<br>27. Manner of Death                                       | 28a. Date                               | of Injury               |              | Time of Inj           |                                     | ry at Work?   | Nursing H    | d. Describe h                  | _             | e 6 🗹              |              | Scene                      |
| ion (tending eath. lor: At   | 틶                | 1 Natural 5 Pend  | ding (Month,                            | Day,Year)               |              |                       |                                     | Yes 2         |              |                                | , <b>-</b> ., |                    |              |                            |
| Division tal or Attendi rs after death. al Director: A   | fica             |   | stigation 28e. Place                    | of Injury - At          | home, fa     | rm, street            | factory, office b                   | uilding, etc. | . 281        | f. Location (S                 | treet and     | Number             | or Rura      | al Route Number, City      |
| Divi   | Certification:   |   | rmined (Specify)                        |                         |              |                       |                                     |               |              | or Town, St                    | ate)          |                    |              |                            |
| Division of Vital Records, P.O. Box 68760, Takthe Haspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi   |                  | 29a. Certifier 1 Certifying Pl  | hysician: To the bes                    | t of my knowle          | edge, dea    | th occurre            | ed at the time, da                  | ate and plac  | ce, and due  | e to the cause                 | e(s) and r    | nanner a           | s stated     | i.                         |
| To the Ho:<br>within 24 h<br>To the Fur<br>completely  | Medical          |   | miner: On the basis of<br>and manner st | of examination<br>ated. | and/or in    | vestigatio            |                                     |               | urred at the | e time, date a                 |               |                    |              |                            |
| -8   | ≥                | 29b. Signature and title of certifie                                    | er 1/                                   |                         | _            |                       | 29c. License                        |               |              |                                |               |                    |              | h, Day,Year)               |
|  |                  | Wolfins V   | ne I'vil                                | £                       |              |                       | O.C.1                               | M.E.          |              |                                | May 2         | 26, 200            | 8            |                            |
| THE PINE   | - [              | <ol> <li>Name and address of person<br/>Margarita Korell MD,</li> </ol> | who completed caus Assistant Med        |                         | ,            | 111 Pe                | nn Street, Ba                       | altimore      | MD 213       | 201                            |               |                    |              |                            |
|  | ate              | 31. Date filed (Month, Day, Year)                                       |   | strar's Signa           | ature a      |                       |                                     |               |              |                                |               |                    | <del></del>  |                            |
| Regist   | rar              | C TAIN  | V 2000                                  | Ester                   | S.           | 1                     |                                     |               |              |                                |               |                    |              |                            |

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Year Month BAKER 200 8 7.21 PM CHARO /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITA 400 D BALT MORE 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Social Security Number 6. Sex **Funeral** Days 1₽M 2□ F Hours Min. 317-38-5724 Director 2-Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside Çity Limits Md. 1 ☑Yes 2 ☐ No Director 5altimone 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 51 "natural", or items 23a edical Examiner must b Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: 3 Widowed 4 Divorced er than "natur ; the Medical E Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DisAble vene 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) Be Wal 2 hair 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 l Bakec SISTER ARTHA 3 & Belverkere 41/C 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If its any injury or o 1 Burial , 3 □Removal from State Barto Carnel Cometer 4 □ Donation 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility ees end way 1639 23a Part1. Enter the disease, or shock, or heart failure. List mediate Cause (Final sease or condition resulting in death) polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death MUDCARDIAL INFARCTION **Physician** /Medical Due to (or as a consequence of): Examiner AIRWAY DISCASE HLONIC OBSTRUCTUE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed as the burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending for use as IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 ☐ Other (specify) Yes 2 No ed by the a detached f 9 Illnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 pe DIMHETES 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed certificate 2 No 1□ Yes Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Director: After or Attending 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral [ Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOUIT RAVEN ZWD BILT 2123 TWRAI ROSEMAKIE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAY 3 0 2008 andes Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-03778 Valerie Barnes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 17485

|  |                | 1- For State<br>Registrar   |   | Certif          | icate of Dea   | ath                                       |                         | Re                     | 9. No.                                       |  |
|--|----------------|---|---|-----------------|--|---|-------------------------|------------------------|--|--|
| Physicia   | n/             | 1. Decedent's Name (First, Middl                                  |   |                 | 0  |   |                         | Date of Deat     Month |  | 3. Time of Death                                     |
| Medical Examin   |                | Valeri  |   | 4               | Barne  |   |                         | May 17, 20             | 008  | 2204 hrs   |
| to kiloma  | ı              | 4a. Facility Name (if not institutio<br>University Hospital       | n, give street and number)  |                 |  | /, Town, or Locatio<br>timore             | n of Death              |                        | 4c. County of De                             | ath  |
| Funeral<br>Director  |                | 5. Social Security Number 214–25–5537                             | /   | (In yrs. last I | Moi  | nder 1 Year If Ur                         | nder 24Hrs.<br>urs Min. | 8. Date of Birt        | h(MW/DD/YYYY) 9.                             | Birthplace (State or reign Country)                  |
|  | #              | House Bosidenes of December                                       | 1 M 2 F   | _/0             | Yrs.   |   |                         | 0-1                    | -1987  | Codility)/VIC  |
| any  | ŀ              | Usual Residence of Decedent<br>10a. State 10b. County             |   | 0c. City. To    | wn or Lecation 4   |   |                         |                        |  | 10d. Inside @ity Limits                              |
| <u>*</u> .   | ٥              | Md  |   | Ba              | 1  | ore                                       |                         |                        |  | 1 Yes 2 No   |
| 5-0036<br>led within 72 hours after death with the Maryland<br>tygiene.<br>other than "natural", or items 23a or 28a-f sho<br>the Medical Examiner must be notified at once  | Director       | 10e. Street and Number  | 2000, Co  | 1               |  | Zip Code                                  |                         | 10                     | Og. Citizen of What C                        | country?   |
| ith with tems 23 st be no  | Funeral        | 11. Marital Status  | 2. Was Decedent E<br>Armed Forces?  |                 | 13. Was Dece   | edent of Hispanic C<br>ecify Cuban, Mexic |                         |                        | 14. Race - An<br>White, etc                  | nerican Indian, Black,                               |
| after des  | by Fu          |   | orced If Yes, Give Year or Dates:   | No              | 1 Yes  | 2 No speci                                | fy:                     |                        | Specify:                                     | BLack:   |
| natur  | 호[             | 15. Decedent's Education (Spe-                                    | cify only highest grade comp  | leted) 16       | Sa. Decedent's Usu   | al Occupation (Giverying life, DO NO      |                         |                        | 16b. Kind of Busine                          | ss/Industry  |
| 215-0036 be filed within 72 h ntal Hygiene, rked other than "r ent, the Medical  | Completed      | Elementary/Secondary (0-12)                                       | College (1-4 or 5+  | )               |  | rier                                      | or use retir            | 60)                    | Reta   | 1  |
| 5-0<br>ed wi   | हो             | 17. Father's Name (First, Middle,                                 |   |                 |  |   | er's Name               | (First, Middle, M      | Maiden Surname)                              |  |
|  | å              | Corey   | J. Bar  |                 |  | S   | tepl                    | ranie                  | 2 tor  | rester   |
| D 2121<br>should be f<br>and Mental<br>7 is marked   | P              | 19a. Informant's Name/ lations                                    | hip (Type, Print)   | ere             | 19b. Mailing Addre   |   |                         | ural Route Num         | ber, City or Town, S                         |  |
| MD 2 sho alth and 2 sho alth and 2 ra 27 is  | 1              | COREY S,  | barnes  | Lach Blac       | 5306 (Disposition (N   | ORRIGO                                    | 300                     | Court<br>Date          | Balt   | 0.11421229   |
| nore, ages la nt of He tr. If ite  | - 1            | 20a. Method of Disposition  1 Burial 2 Cremation                  | 3 Removal from State  | cren            | natory or other pla  |   | العر                    | ( 1                    | 20c. Location - City                         | or rown, State                                       |
| 드러워트님  |                | 4 Donation 5 Other St   |   | Mou             |  |   | 4 5/                    | 27/08                  | Balto  | · rud;   |
| Baltimo<br>permit. Pag<br>Department<br>Important:<br>injury or of   |                | 21. Sign ture of Funeral Service                                  | Litensee  |                 | 22. Name a   | nd Address of Fac                         | Me                      | GEES 1                 | sexu falls                                   | low page   |
| Physician  | +              | 23a. Part I. Enter the disease of                                 | complications that caused th  | e death. Do     | not enter the mod  | le of dving, such a                       | cardiac or              | respiratory arre       | St. shock or heart                           | MA-QIQIZ Approximate Interval                        |
| /Medical   | X              | failure. List only one cause                                      | on each line.   |                 |  |   |                         |                        |  | Between Onset and Death                              |
| xaminer  |                | Immediate Cause (Final 7 sease or condition resulting in reath)   | a. Multiple Gunshot  Due to (or as a conseq   |                 |  |   |                         | _/                     |  |  |
|  |                | Sequentially list conditions,                                     | b   |                 |  |   |                         |                        |  |  |
|  | Examiner       | if any, leading to immediate cause. Enter Underlying Cause        | Due to (or as a conseq  | uence of):      |  |   |                         |                        |  |  |
| · 8. =   | хаш            | (Disease or injury that initiated events resulting in death) Last | Due to (or as a conseq  | uence of):      |  |   |                         |                        |  | 1  |
| transit  |                |   | d   |                 |  |   |                         |                        |  |  |
| 760,<br>cate be exe<br>physician<br>he burial  | n/Medical      | UNPENDED  | X AMENDED<br>#5, DETFH.G  | 380 6/1         | 0/08 TT  |   |                         |                        |  |  |
| 8760,<br>tificate be er<br>ng physiciar<br>as the burial   | Š,             | IF FEMALE:<br>23b. Was decedent pregnant in the                   | 23c. If yes, outcome  | of pregnan      | icy  |   |                         |                        | 23d. Date of deli                            |  |
| OX 68'   | Siar           | past 12 months?   | 1 Live birth 4 Pregnant at til  | me of death     | 2 Fetal dea  |   | pic pregnar             | ncy                    | Month  | Day Year   |
| Box 68<br>e death certi<br>the attendin<br>ed for use a  | Physicia       | 1 Yes 2 No 9 V Unit   | nown 9 Unknown  |                 | o [ ] Other (5   | pecis)                                    |                         |                        | 2  | _  |
| that the   |                | Part II. Other significant condit                                 | ions contributing to death t  | out not resul   | Iting in the underly   | ing cause given in                        | Part I.                 | 23e. Did to            | bacco use contribute                         | to the cause of death?                               |
| ries th  | g<br>p         |   |   |                 |  |   |                         | 1 Yes                  | 2 V No 3                                     | Probably 4 Unknown                                   |
| cords, P<br>law requires t<br>has been sign  | Completed      |   |   |                 |  |   |                         | 24a. Was autop         |  | autopsy findings available to completion of cause of |
| ecc<br>he lav  | Ĕ              |   |   |                 |  | •   |                         | perfor                 | med? death                                   | 1?   |
| tal Rection: The certificate   | Bec            | 25. Was case referred to medical                                  |   |                 |  | 26.Place of Dea                           | th (Check o             |                        |  |  |
| Vita<br>hysici<br>I direc  | 2 B            | examiner?<br>1 ✓ Yes 2 No   | Hospital: 1 Inpatient   | 2 🗸 ER          | NOutpatient 3  | DOA Other                                 | Nursing                 | g Home 5               | Residence 6 0                                | ther:  |
| of<br>ing Pl<br>After<br>'unera'   |                | 27. Manner of Death   | 28a. Date of Injury<br>(Month, Day Yea<br>May 17, 2008  | 28              | b. Time of Injury  | 28c. Injury at We                         |                         | 28d. Describe h        | now injury occurred                          |  |
| ion<br>ttendi<br>feath.<br>ttor:   | 읉              | Natural 5 Pend Accident Inves                                     | ing May 17, 2008<br>stigation   | 00              | 000 hrs  | 1 Yes 2                                   | ✓ No                    | Subject sno            |  |  |
| Division of Vital Records, P.O. Ital or Attending Physician: The law requires that the safter death.  In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in the funeral director.  | Certification: | 3 Suicide 6 Coul  | d not be 28e. Place of Inju   | -               | e, farm, street, facto   | ory, office building,                     |                         |                        |  | Rural Route Number, City                             |
| Spita<br>hours<br>ineral   |                | 4 Momicide  | mined (Specify) Dwe   |                 |  |   |                         |                        | tate)<br>venue, Baltimore,                   |  |
| Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - tran | 10             | Check only  | nysician: To the best of my li<br>miner:On the basis of exami<br>and manner stated.   |                 |  |   |                         |                        |  |  |
| F>Fō   | ž              | 29b. Signature and title of certifie                              | r   |                 |  | 29c. License numb                         | er                      |                        | 29d. Date signed (                           | Month, Day, Year)                                    |
|  |                | his his   | , m.D   |                 |  | O.C.M.E.                                  |                         |                        | May 18, 2008                                 |  |
| $\phi$   |                | 30. Name and address of person<br>Ling Li, MD Assista             | who completed cause of dea  |                 | a)<br>enn Street, Ba   | ltimore MD 2                              | 1201                    |                        | <u>.                                    </u> |  |
| Sta  | ite            |   | All sections and the section of the | Signature       | aceds P  |   | .201                    |                        |  |  |
| - Ju   | ar             | 31. Date filed (Month, Day, Year)                                 | 18 Carlina A  | J. 15           | The state of the s |   |                         |                        |  |  |

| 8-03956  |                | Please Type or Print in Black Indelible Ink. Ensure  |                     |                                 | ible.   |  |
|--|----------------|--|---------------------|---------------------------------|---|--|
| homas M. Bills   |                | State of Maryland / Department of Health and 1-For State Certificate of Death  | d Mental Hy         | giene                           | 200   | 8 1748                                   |
| Physici  |                | Registrar  1. Decedent's Name (First, Middle,Last)   |                     | Reg<br>2. Date of Death         | g. No.  | 3. Time of Death                         |
| Medical Exami  | 200            |  |                     | Month<br>May 23, 20             | Day Year<br>008   | 2253 hrs                                 |
| <b>k</b> .   |                | 4a. Facility Name (if not institution, give street and number)  4b. City, Town, or   | Location of Death   |                                 | 4c. County of Deat                                      |  |
|  |                | St. Joseph's Hospital Towson   |                     |                                 | Baltimore Co  |  |
| Funeral<br>Director  |                | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Months Days  |                     | 1                               | (MM/DD/YYYY) 9. Bi<br>Forei                             | thplace (State or Endicott, ountry) N.Y. |
| Director   |                | 219-56-6923 1 XM 2 F 5/ Yrs.   |                     | Aug.27                          | 7,1950 c  | ountry) N.Y.                             |
| áu.  |                | Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  |                     |                                 |   | 10d. Inside City Limits                  |
| rd<br>how a  | _              | Maryland Baltimore County Parkville  |                     |                                 |   | 1 Yes 2 No                               |
| Maryland<br>28a-f show any<br>datonce,   | 5              | 10e. Street and Number 10f. Zip Code   |                     | 10                              | g. Citizen of What Cou                                  | Intry?                                   |
| 5<br>72 hours after death with the Maryland<br>n "natural", or items 23a or 28a-f sho<br>al Examiner must be notified at once.   | Director       | 8810 Littlewood Road   | 21234               |                                 | United Sta  | ites                                     |
| with ms 23   | Funeral        | 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of His  |                     |                                 |   | ican Indian, Black,                      |
| death<br>or ite  | Ē              | 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban  |                     | rican, etc.)                    | White, etc.   | Mite                                     |
| s after  | þ              | 3 Widowed 4 Divorced If Yes, Giva Year or Dates:   |                     |                                 | Specify.  |  |
| 2 hours<br>"natur  | ted            | 15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  16a. Decedent's Usual Occupate during most of working life.   |                     |                                 | 16b. Kind of Business                                   | industry                                 |
| 336<br>thin 7<br>re.<br>than   | Completed      | 12 N/A Disable   | ed                  |                                 | Disa  | bled                                     |
| 215-003(<br>be filed within<br>rited Hygiene.<br>riked other tha   | ပ္ပြ           | 17. Father's Name (First, Middle, Last)  | 18.Mother's Name    | First, Middle, M                |   |  |
| 21215-0036<br>hould be filed within 72 hou<br>nd Mental Hygiene.<br>is marked other than "nat<br>tite event, the Medical Exa   | Be             | Donald Richard Bills, Sr.  | Rachel E            |                                 |   |  |
| hound hour is a  | ပ              | 19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stree  Mr. Donald R. Bills, Sr. (Father)   3 Via Lucindia  |                     |                                 |   |  |
| imore, MD 2<br>Pages I and 2 shoument of Health and I tant: If item 27 is root of the realth and I tant: If item 27 is root of the traumatic   |                | 20a. Method of Disposition 20b. Place of Disposition (Name of cer  |                     | Date                            | Point, Fla  |  |
| ore<br>ges I<br>t of H<br>t If in  |                | 1 Burial 2 Cremation 3 Removal from State crematory or other place) Evans Funeral Char   | May                 | 29,                             | ·   |  |
| Baltimore,<br>permit. Pages I ar<br>Department of Hee<br>Important: If ite   |                | 4 Donation 5 Other Specify:  |                     |                                 |   | 1,Maryland                               |
| Baltimore, MI permit. Pages I and 2 s Department of Health at Important: If item 27 injury or other traum  | 8 33           | Peaceful A   | lternativ           | es Fune                         | eral&Cremat   | ion Ctr.,P.A<br>21093                    |
| Physician  |                | 232. Part I Prite the disease, or complications that caused the death. Do not enter the mode of dying,   |                     |                                 |   | Approximate Interval                     |
| /Medical<br>~xaminer   | 9              | fajfurg/ List only one cause on each line. Immediate Cause (Final disease a Smoke Inhalation   |                     |                                 |   | Between Onset and<br>Death               |
| ,  |                | or condition resulting in death)  Due to (or as a consequence of):   |                     |                                 |   |  |
|  | ᆸ              | Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  |                     |                                 |   |  |
|  | Ē              | Course Enter the deriving Course (Disease or injury that initiated   |                     |                                 |   |  |
| nsit ed  | Examiner       | events resulting in death) Last Due to (or as a consequence of):   |                     |                                 |   |  |
| ox 68760,<br>eath certificate be executed<br>attending physician and<br>for use as the burial - transit  | ical           | d. UNPENDED AMENDED  |                     |                                 |   |  |
| 60,<br>ate be<br>hysici<br>e buri  | Physician/Medi | IF FEMALE: 23c. If yes, outcome of pregnancy   |                     |                                 | 23d. Date of delive                                     | ~  |
| 687<br>ertifica<br>ding p  | an/            | 23b. Was decedent pregnant in the past 12 months?  | Ectopic pregnar     | ісу                             | Month   | Day Year                                 |
| OX<br>leath o  | sici           | 1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)   |                     |                                 | Ì   |  |
| b.O. Be<br>that the de<br>ned by the<br>detached f   | Ph             | Part II. Other significant conditions contributing to death but not resulting in the underlying cause g  | given in Part I.    | 23e. Did to                     | bacco use contribute to                                 | the cause of death?                      |
| cords, P.O. law requires that has been signed b  | by             |  |                     | 1 Yes                           | 2 No 3 Pro  | bably 4 Unknown                          |
| Division of Vital Records, tal or Attending Physician: The law requirirs after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should the complete tall of the funeral director.   | ompleted       |  |                     | 24a. Was a                      |   | utopsy findings available                |
| ec law<br>te has<br>ge 2 s   | 립              |  |                     | autops                          | med? death?   | completion of cause of                   |
| Vital Rec<br>ysician: The l<br>his certificate b   | O              | 25. Was case referred to medical 26.Place  | e of Death (Check o |                                 | Z W NO  | es 2 140                                 |
| Vita<br>nysicia<br>this ce   | o Be           | examiner? 1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA  | Other Nursing       | Home 5                          | Residence 6 Othe  | er:                                      |
| n of Vital Reco<br>ding Physician: The law<br><br>After this certificate has<br>funeral director, page 2 s   | اءَ            | (Month Day Year)   |                     |                                 | now injury occurred m of house fire                     |  |
| sion<br>ttend<br>death.<br>ctor:   | ațio           | 2 Accident Investigation   | Yes 2 No            | Jabjoot violi                   | in or nodec inc   |  |
| JVIS<br>after A<br>d in b  | Certification: | 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office b   | ouilding, etc.      | 28f. Location (S<br>or Town, St | treet and Number or R<br>tate)<br>of Road, Parkville, N | ural Route Number, City                  |
| ospita<br>hours<br>nnera   |                | 4 Homicide determined (Specify) Single Family  29a. Certifier 1 Certifying Physician: To the best of my knowledge death occurred at the time day   |                     |                                 |   |  |
| Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri | Medical        | one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion  |                     |                                 |   |  |
| To To con  | Mec            | and manner stated.  29b. Signature and title of certifier  29c. License  |                     |                                 | 29d. Date signed (Me                                    |  |
|  | (5)            | Don m ) int into   | M.E.                |                                 | May 24, 2008  |  |
|  | ł              | 30. Name and address of person who completed cause of death (Item 23a)   |                     |                                 |   |  |
| 13   |                | Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street,  | , Baltimore, Mi     | 21201                           |   |  |
|  |                | ESTATE TO THE TOTAL OF THE TOTA |                     |                                 |   |  |
| Regist   | ueli           | MAI O LOO POLICE   |                     |                                 |   |  |

DHMH 17 Rev 1/2001 OCME 2006

|                     |   |                  | State of Maryland / Dep  | eartment of Health and Mertificate of Death   | lental Hygie                                | •  | 17487                             |
|---------------------|---|------------------|--|---|---|--|-----------------------------------|
|                     | Physic  | ian              | 1. Decedent's Name (First, Middle, Last)   |   | Date of Death     Month                     |  | 3. Time of Death                  |
| 44                  | /Medi   | cal              | Ruby M. Bond   |   | May   | 27 2008  | 4:05 PM                           |
| 2                   | Exami   | ner              | 4a. Facility Name (If not institution, give street and number) Heartlands Assisted Living  | 4b. City, Town, or Location of Death Severna Park   |   | 4c. County of Death                                  | 1                                 |
|                     | Funoval   |                  | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,  |   | 8. Date of Birth                            | Anne Aru   |                                   |
|                     | Funeral<br>Director   |                  | 023-05-3849 1□ M 2☑ F 96 Yrs.  Usual Residence of Decedent   | Months Days Hours Min.  | (Month, Day, Ye<br>Nov. 10                  | ear) Country   | e (State or Foreign<br>)<br>MA    |
|                     | anyland<br>show   | 7                | 10a. State 10b. County 10c. City, Town or L  |   |   | 10d  | Inside City Limits 1 ☐ Yes 2 ☐ No |
|                     | the M<br>28a-f<br>notifie   | ecto             | Maryland   Anne Arundel  10e. Street and Number  | Pasadena<br>10f. Zip Code   | 100   | . Citizen of What Country                            |                                   |
|                     | h with<br>23a or<br>st be   | Funeral Director | 1541 Marco Drive   | 21122   | Tog.  | USA  | :                                 |
|                     | ems a   | ner              | 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13.   | Was Decedent of Hispanic Origin? (Spe<br>If Yes, specify Cuban, Mexican, Puerto             | ecify Yes or No-                            | 14. Race - American                                  |                                   |
| 036                 | be filed within 72 hours after death with the Maryland that Hyglene.  Ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at   | by               | 3 ☑ Widowed 4 ☐ Divorced   | 1 ☐ Yes 2 ☐ No Specify:   | ritali, etc.)                               | Black, White, etc                                    | ite                               |
| 21215-0036          | nin 72 ha<br>r.<br>n "natu<br>Medical   | Completed        | 15. Decedent's Education (Specify only highest grade completed) (Give  | edent's Usual Occupation<br>e kind of work done during most of worki<br>DO NOT use retired) | ng   16l                                    | b. Kind of Business/Indus                            | try                               |
| 77.                 | d with<br>glene<br>er tha<br>the I  | ĕ                | Elementary/Secondary (0-12) College (1-4or 5+) 12  | Homemeaker  |   | Househo  | ld                                |
| 2                   | al Hy<br>al Hy<br>d othe  | Be (             | 17. Father's Name (First, Middle, Last)  | 18. Mother's Name   | (First, Middle, Mai                         | iden Surname)  |                                   |
| <u>X</u>            | should be and Mental s marked o   | 2                |  | Eliza   | beth A                                      | . Reille   | У                                 |
| Baitimore, Maryland | es 1 and 2 should by Health and Ment item 27 is marked rother traumatic er other traumatic er   | П                |  | ing Address (Street and Number or Rura  |   |  | ode)                              |
| <b>∠</b><br>as`     | es 1 and 2<br>of Health a<br>f item 27 Is<br>r other tra  |                  |  | 1 Marco Drive, Pas  |   |  |                                   |
| <u> </u>            | Pages 1<br>ment of H<br>ant: If ite<br>ury or ot  |                  | To banda 2 Goternation 5 of territoval notificiate 1 1,  | ematory or other place)   Mav   | 29  | c. Location - City or Town                           |                                   |
|                     | it. Pa<br>rtmer<br>rtant:<br>njury  | 1.0              | T Bonanon o Comer (cocony)   |   | 008 B                                       | altimore, Ma   | ryland                            |
| ğ                   | permit. Page<br>Department of<br>Important: If<br>any Injury or<br>once.  |                  | 21. Signatule of Fune -   Servick Licentee   2   | 2. Name and Address of Facility   |   | s Funeral Ho   |                                   |
| -                   | -   |                  | 23a. Part . Enter the disease, or complications that aused the death. Do not en shock, or heart failure. List only one cause on each line.   | 3111 Mountain Road  | a, Pasade<br>or respiratory arrest.         | na, MD 21121   | oproximate                        |
|                     | Physician   |                  | Immediate Cause (Final disease or condition  | HEART FAILU   |   | In O   | terval Between<br>nset and Death  |
|                     | /Medical<br>Examiner  |                  | resulting in death)  Due to (or as a consequence of):  | TIENT   |   |  |                                   |
|                     | LAdillilei  | _                | Sequentially list conditions, b.   |   |   |  |                                   |
|                     | ted<br>1sit   | Examiner         | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Course Cou |   |   |  |                                   |
|                     | be executed<br>ician and<br>burial-transit  | xar              | that initiated events resulting in death) Last C. Due to (or as a consequence of):   |   |   |  |                                   |
| 08/00,              |   | calE             |  |   |   |  |                                   |
| Q                   | certificate<br>iding physise as the   | -                |  |   |   |  |                                   |
| O. BOX              | To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. within 24 hours after death. completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director, page 2 should be detached for use as the completely filled in by the funeral director. | Physician/Med    |  | □Ectopic pregnancy<br>□ Other (specify)   |   | 23d. Date of delivery<br>Month Da                    | y Year                            |
| Z.                  | hat th<br>d by  | 문                | Part II. Other significant conditions contributing to death but not resulting in the u   | underlying course given in Bort I   | 22a Did tohaa                               | co use contribute to the c                           | anna of death?                    |
| necords,            | signe<br>d be   | l by             | HYPERTENSION   | moonying oddae giveri ii i arri.  | 1 Tyes                                      |  | y 4 []Unknown                     |
| į.                  | v requ  | etec             |  |   |   | _  | , –                               |
| ב<br>ב<br>ב         | : The lavicate has  | Completed by     |  |   | 24a. Was an autopsy performed               | d?   death?  | etion of cause of                 |
| <u> </u>            | siciar<br>certif<br>recto   | Be               | 25. Was case referred to medical examiner?  Hospital: Hospital:  | 26. Place of Death  |   | DCS150   | ED LIVIN                          |
| 5                   | Physic refriseral di  | To               | 1 ☐ Yes 2 ☐ No   | nt 3 DOA States 4 Nursing Hor  28c. Injury at 2   | ne 5 Residence<br>28d. Describe how i       | e 6 Dother (Specify)                                 | -9 -1777                          |
| 5                   | ndlng<br>th.<br>: Afte  | tion             | 1 🔀 atural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation   | Work?<br>M 1 ☐ Yes 2 ☐ No   | ou. Decombe new i                           | injury occurred                                      |                                   |
| DISINI              | l or After<br>after dea<br>Director<br>I in by the  | Certification:   | 3 ☐ Suicide  3 ☐ Suicide  4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of injury - At home, farm, str building, etc. (Specify)  |   | 28f. Location (Stree<br>City or Town, S     | t and Number or Rural R<br>itate)                    | oute Number,                      |
|                     | te Hospita<br>24 hours<br>1e Funeral<br>letely filler   | Medical C        | 29a. Certifier (Check only one)  1 Sertifying Physician: To the best of my knowledge, deat and manner stated.  | th occurred at the time, date and place, a<br>nvestigation, in my opinion, death occurr     | and due to the caus<br>ed at the time, date | e(s) and manner as state<br>and place, and due to th | ed.<br>e cause(s)                 |
|                     | Vithir<br>To th<br>comp   | Me               | 29b. Signature and title of certifier  | 29c. License number   | 29d.  | Date signed (Month, Day                              | v, Year)                          |
| )                   |   |                  | inforces and   | D57531  | $\sim$                                      | AY 28,0  | 20025                             |
|                     | V   |                  | 30. Name and address of person who completed cause of death (Item 23a) (Type, 86 of Veterans H  31. Date filed (Month, Day, War)  32. Regularar's Signature  | Print)  |   |  |                                   |
| 1                   | 0   |                  | many Negi 8601 Veterans H  | wy, Suit 204,   | millersv                                    | The mo .   | 21108                             |
|                     | Sta   | ite              | 31. Date filed (Month, Day, War)  32. Registrar's Signature  | (marks)   |   | -  |                                   |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2008 2:50 Seconious /Medical Bivens 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 5249 Cedgate Road Baltimore N/A 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** 1 ☑ M 2 □ F Days 216-40-2085 Director 1-18-1942 GA Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wydical Evan That must be notified 31 once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 TyYes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11. Marital Status

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?
1 Yes, 2 Mo If Yes, Give Year or Dates: Funeral 21206 A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Baltimore, Maryland 21215-0036 1 □Yes 21☑No Specify ģ Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th grade College (1-4or 5+) Store Keeper Verizon 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Bivens Eva Miles ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5249 Cedgate Road Balto, MD 21206 Hattie Bivens -Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 5-28-2008 Baltimore, Greenmount Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. North Avenue Balto, MD 21202 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** flod9 /Medical Due to for as a consequence of). **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed physician and the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical the attending posterior IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 **N**0 3 Probably 4 Unknown 1 ☐ Yes After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tipe of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

3 L Date filed (Month, Day, Year)

32. Registrar's Signature

iphia Rd Suite 208 Balto. Md 21237

State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 17489 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27<sup>Day</sup> Month 5 **Physician** Ralph 2008 Young Beasley 10:15 pM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5000 Loch Raven Blvd Balto N/A 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7-2-1940 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 ₩ 2 □ F 220-36**-**8294 Director 67 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it e Modical Examiner must be recitied at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1□Yes 2□No Directo MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 Loch Raven Blvd 21239 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Black Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk Elementary/Secondary (0-12) 8th grade College (1-4or 5+) Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shelton Samuel Beasley Nancy Tucker မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucille Beasley - Sister 5000 Loch Raven Blvd Balto, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or oth Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arbutus Memorial 6-2-2008 Arbutus, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H la 1101 E. North Avenue Balto, MD Warrer 21202 23a. Part 1. Enter the disease, or comilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) m /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading Limited States Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No After this certificate has autopsy performed?

1 □ Yes 2 No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 200 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Autural 5 Pending investigation To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide \*\*Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number P2039629b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blvd #103 Balto. MD. 21239 Hahn 5601 Loch Davis 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008 

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** WAZA AMIE 200f MAY 24 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** JOHNS HOPKINS BAYVIEW MEDICAL CENTO BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3.23.193. 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 🗗 Director Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at 12 Yes 2 No Director altimore 10g. Citizen of What Country? 10f. Zip Code 6 St. Georges Ave ab12items 23a by Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. ☐Yes 2☐₩6 Yes, Give 1 ☐ Never Married 2 ☐ Married ō Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: 3 Nidowed 4 Divorced Year or Dates: 'natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than amy injury or other traumatic event, the Mangne. State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ourse P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Garrisonville AdStafford, VA 22556 Sharon D. Berryman 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 22. Name and Address of Facility Lugan C. Green French Services 1 ☐ Barial 2 ☐ Cremation 3 ☐ Removal from State King Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. And Baltimore, MD 21212 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MUSTIPLE ORGAN SYSTEM disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to for as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No 1X Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 2 No 1 npatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of D ath 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours aft

To the Funeral Di

completely filled in

Director:

0,

Medical

Registrar

JUSTIA R. PriCE M. D State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

RES-000

27,2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 30

AVENE BACTIMENE, MD 4940 EASTERN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death **Physician** /Medical Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner oice If Under 1 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Days Months Min. **Director** Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location show 27 Is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be motified at 1 ☐ Yes 2 No **Funeral Director** 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" And Other traumatic event. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4or 5+) 95UI 501 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21239 NRI tarkville 1 Burial 2 ☐ Cremation 3 ☐ Removal from State.
4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 23a. Part 1. Enter the disease, shock, or heart failure. L e, or complications that caused the death. Do not enter the mode of cying, List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ROSTATE Corncer 1enVS /Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 1 No 3 ☐ Probably 4 ☐ Unknown page 2 should Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) Will (4 Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 1/2001

AMON

31. Date filed (Month, Day, Year) MAY 3 0

6701

N. Churces (+ Tavor no 2,204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M7 32. Registrar's Signature

CHAMES

2008

MAY 25 200

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No 2008

2008

ACCURA

USA

Month

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

9. Birthplace (State or Foreign Country)

GHANA,

X Yes 2 No

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

24b. Were autopsy findings available prior to completion of cause of death?

2008

may 21

1 ☐ Yes 2 ☐ No

Day

2. Date of Death

Month

1. Decedent's Name (First, Middle, Last)

**Physician** 

DHMH 17 Rev 1/2001

State Registrar Michalus IN Kontrelatos

Year)

31. Date filed (Month, Day,

preted cause of death (Item 23a) (Type, Print) KX 11065 Little Patuxent Partury Columbia Many lang

| eather Angel E   | Baue                      | Ctate of Maryland / Bepartin  | nent of Health and Mental H   | _                                       | 200                                     | 12 171.0   |  |  |  |
|--|---------------------------|---|---|---|---|--|--|--|--|
|  |                           |   | cate of Death   |   | g. No.                                  |  |  |  |  |
| Physici<br>edical Exami  |                           | 1. Decedent's Name (First, Middle,Last) Heather Angel Bauer   |   | 2. Date of Death<br>Month<br>May 23, 20 | n<br>Day Year<br>108                    | 3. Time of Death<br>1619 hrs                       |  |  |  |
| · ·  |                           | Facility Name (if not institution, give street and number)     Harbor Hospital Center   | 4b. City, Town, or Location of Death<br>Baltimore   |   | 4c. County of Death                     |  |  |  |  |
| Funeral  |                           | 5. Social Security Number 6. Sex 7. Age (In yrs. last bit   |   |   | (MM/DD/YYYY) 9. Birt<br>/1073 Foreig    |  |  |  |  |
| Director   |                           | 216-86-7323 12 2 <b>X</b> F 34  | Yrs. Months Days Hours Min.   | 11/01                                   | /19/3 Col                               | n<br><sub>untry)</sub> W.Va.                       |  |  |  |
| any  |                           | 10a. State 10b. County 10c. City, Town  |   |   | 1                                       | 10d. Inside City Limits                            |  |  |  |
| daryland<br>28a-f show<br>1 at once.   | tor                       |   | klyn Park   |   |   | 1 Yes 2 No   |  |  |  |
| the Mar<br>or 28a  | Director                  | 10e. Street and Number 183 West Meadow Rd.  | 10f. Zip Code 21225   | 10                                      | g. Citizen of What Cour<br>USA          | itry?  |  |  |  |
| th with tems 23s   | eral                      | 11. Marital Status 12. Was Decedent Ever in U.S.  | 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto              |   | 14. Race - Ameri<br>White, etc.         | can Indian, Black,                                 |  |  |  |
| Baltimore, MD 21215-0036  Depenit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Filed and Mental Hygiewie, Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once | / Fune                    | 1 Never Married 2 Married 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year   | 1 Yes 2 No specify:   | , , , , , ,                             | Specify: Whi                            | te   |  |  |  |
| nours a<br>natura<br>Xamir   | ed by                     |   | Decedent's Usual Occupation (Give kind of videring most of working life. DO NOT use retired.) |   | 16b. Kind of Business/I                 | ndustry  |  |  |  |
| 36<br>hin 72 l<br>te.<br>than ",   | Completed                 | Elementary/Secondary (0-12)  College (1-4 or 5+)  | Homemaker   |   | Home                                    |  |  |  |  |
| 21215-0036 und be filed within 7 Mental Hygiene, marked other than   |                           | 17. Father's Name (First, Middle, Last)   | 18.Mother's Name  |   |   |  |  |  |  |
| 2121<br>ald be f<br>Mental<br>marked<br>event,   | o Be                      | Denzil Parle Currence  19a Informant's Name/Relationship (Type, Print)  15  | Virgini 9b. Mailing Address (Street and Number or F   |   | Wright                                  | Zin Code)  |  |  |  |
| MD 3<br>nd 2 shot<br>alth and<br>m 27 is a   |                           | Paula Nyberg, sister  |   |   | Md. 21225                               | , Zip oddo)  |  |  |  |
| Ore,<br>ses 1 an<br>of Hea<br>If iter  |                           | 20a. Method of Disposition  20b. Place  1 Burial 2 Cremation 3 Removal from State  RAY  20b. Place  | of Disposition (Name of cemetery, atory or other place) VIEW CREMATORY 5                      | Date                                    | 20c. Location - City or                 |  |  |  |  |
| Baltimore,<br>permit. Pages 1 an<br>Department of He<br>Important: If ite  | -2                        | 4 Donation 5 Other Specify:   | 22. Name and Address of Facility Gor  | /30/08                                  | Baltimore,                              |  |  |  |  |
| Derm Derm Impurinju  | 6 }                       | Jane W Bransows KI  | 4001 Ritchie Howy   | . Balto                                 | . Md. 21225                             |  |  |  |  |
| Physician<br>/Medical  | SS (0                     | 23a. Part I. Enter the disease, or complications that caused the death. Do r failure. List only ope cause on each line.   | not enter the mode of dying, such as cardiac o  | r respiratory arre                      | st, shock, or heart                     | Approximate Interval<br>Between Onset and<br>Death |  |  |  |
| <sup>ः द</sup> xaminer   |                           | Immediate Cause (Final disease or condition resulting in death)  a DITITIAZEM AND NOT   | rtrityline intoxicati   | .on                                     |   | Death  |  |  |  |
| - 1  | er                        | Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):  |   |   |   |  |  |  |  |
| - N  | Examiner                  | cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   C. Due to (or as a consequence of):   |   |   |   |  |  |  |  |
| ecuted<br>and<br>transit   | al Ex                     | d.  | -000 6_11_00  |   |   |  |  |  |  |
| 0,<br>e be exe<br>ysician<br>burial -  | edical                    |   | <b>3880 6-11-08 vt</b><br>7,28a-f,perME.g881 7/   | 8/08 TT                                 |   |  |  |  |  |
| tox 68760, eath certificate be executed to attending physician and for use as the burial - transit   | an/M                      |   | / 2 Fetal death 3 Ectopic pregna  | incy                                    | 23d. Date of delivery<br>Month          | y<br>Day Year                                      |  |  |  |
|  | Physician/Me              | 1 Yes 2 No 9 V Unknown 9 Unknown  | 5 Other (Specify)   |   |   |  |  |  |  |
| 5, P.O. B<br>ires that the d<br>is signed by the   | by Pr                     | Part II. Other significant conditions contributing to death but not resulting   | ng in the underlying cause given in Part I.   | 23e. Did to                             | bacco use contribute to                 |  |  |  |  |
| ds, Fequires   | eted                      | Myocardial fibrosis   |   | 24a. Was a                              | n   24b. Were au                        | topsy findings available                           |  |  |  |
| Division of Vital Records, tal or attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be   | Completed                 |   |   | autops<br>perfor<br>1 ✓ Yes 2           | med? death?                             | completion of cause of                             |  |  |  |
| tal R<br>ian: T<br>certifica<br>ector, pa  | Be C                      | 25. Was case referred to medical examiner?  | 26.Place of Death (Check  |   |   | 5 2 10   |  |  |  |
| of Viting Physic<br>After this current dire  | ြ                         | 1 Yes 2 No No Inpatient 2 YER/C   |   |   | Residence 6 Other                       | ·  |  |  |  |
| ion C<br>tending<br>eath.<br>or: Af  | ation                     | 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred unk 28d. Describe how injury occurred unk |   |   |   |  |  |  |  |
| Division To the Hospital or Attent within 24 hours after death To the Funeral Director:  | Certification:            | 3 Suicide 6 X Could not be 28e. Place of Injury - At home, t  | farm, street, factory, office building, etc.  | 28f. Location (S<br>or Town, St         | treet and Number or Ru<br>ate) 4900 Rit | ral Route Number, City                             |  |  |  |
| Hospita<br>Hospita<br>24 hours<br>Funeral<br>ely fille   |                           | 4 Homicide determined (Specify) Mote1  29a. Certifier 1 Certifying Physician: To the best of my knowledge, de   |   | Km 12/ E                                | rooklyn, M                              | D  |  |  |  |
| Fo the within 2 Fo the Complet   | and place, and due to the |   |   |   |   |  |  |  |  |
|  | Medical                   | 29b. Signature and title of certifier   | 29c. License number O.C.M.E.  |   | 29d. Date signed (Mod<br>May 24, 2008   | nth, Day, Year)                                    |  |  |  |
| D. pk  |                           | 30. Name and address of person who completed cause of death (Item 23a)  | O.O.M.E.  |   | , 2 1, 2000                             | - C  |  |  |  |
| 1  | 7                         | Margarita Korell MD. Assistant Medical Examiner   | 111 Penn Street, Baltimore, MD  | 21201                                   | ····                                    |  |  |  |  |
| St<br>Regist   | ate<br>trar               | 31. Date filed (Nonth, Day Year) 2008 32 egistrar's Signature   | Soul  |   |   |  |  |  |  |

|   |   |                | For State   | State of Ma  |  | epartment of F   |   | lental Hyg                                   | iene                                    |  |  |  |  |
|---|---|----------------|---|--|--|--|---|--|---|--|--|--|--|
|   | . 27  |                | Registrar  1. Decedent's Name (First, Mid   | Idla Last  | (  | Certificate of   | Death   | 2. Date of Deat                              | eg. No. 200                             | )8 1 <i>7</i> 495  |  |  |  |
| 20  | Physici<br>/Medi  |                | Allan Brause  | ale, Last)   |  |  |   | Month May 22,                                | Day Ye                                  | ear 2:00 AM M  |  |  |  |
|   | Examir  |                | 4a. Facility Name (If not instituti   |  |  | 4b. City, Town, or   | r Location of Death                                     |  | 4c. County of                           | Death  |  |  |  |
|   |   |                |   | Medical Cente  |  | Annapo   |   |  | Anne Ar                                 |  |  |  |  |
| s   | Funeral<br>Director   | i i            | 5. Social Security Number 071–34–0626   | 6. Sex 7. Age 1  | e (In yrs. last birth                    | day) If Under 1 Year Months Days   | If Under 24 Hrs.<br>Hours Min.                          | 8. Date of Birth<br>(Month, Day,<br>July 27  | Vear)                                   | Birthplace (State or Foreign<br>Country)<br>New York                             |  |  |  |
|   | land<br>w   |                | Usual Residence of Decedent  10a. State 10b. Coun   | ty   | 10c. City, Town                          | or Location  | _   |  |   | 10d, Inside City Limits  |  |  |  |
|   | Mary<br>I-f sh  | tor            | MD Ann  | e Arundel  | Anna                                     | polis  |   |  |   | 1 □Yes 21 No   |  |  |  |
|   | th the<br>or 28a<br>e notl  | Director       | 10e. Street and Number  |  |  | 10f. Zip Code  |   | 10   | 0g. Citizen of Wha                      | at Country?  |  |  |  |
|   | 23a cust b  |                | 788 Eastern Po  | oint Road  |  | 2  | 1401  |  | US                                      | SA   |  |  |  |
| 9   | n 72 hours after death with the Marylan<br>"natural", or items 23a or 28a-f show<br>edical Examiner must be notified at | Funeral        | 11. Marital Status 1 □ Never Married 2 ☑ Ma   | If Van Ohio  | No                                       | <ol> <li>Was Decedent of H         If Yes, specify Cuba     </li> <li>Yes 2X No</li> </ol> | lispanic Origin? (Sp<br>an, Mexican, Puerto<br>Specify: | ecify Yes or No-<br>Rican, etc.)             | Black, 1                                | American Indian,<br>White, etc.  |  |  |  |
| 200   | hours<br>ural",   | d by           | 3 Widowed 4 Divorce   | ed Year or Dates:  |  |  |   |  |   | white<br>mess/Industry unk   |  |  |  |
| -6121   | 72<br>Tic   | Completed      | (Specify only high<br>Elementary/Secondary (0-12)   |  |  |  |   |  |   |  |  |  |  |
| N   | filed v<br>Hygie<br>ther t  | ပ္ပိ           | 12 17. Father's Name ( <i>First, Middle</i>   | 5+   |  | chemis   | 18. Mother's Nam  | e (First Middle M                            | Maiden Surname)                         |  |  |  |  |
| a   | ld be ental   | To Be          | Walter Brau   |  |  |  |   | n Willen:                                    | ,                                       |  |  |  |  |
| ar∠   | d 2 should<br>th and Mer<br>7 is marke<br>traumatic   | ۲              | 19a. Informant's Name/Relation  |  | 19b. N                                   | Mailing Address (Street  |   |  | Number, City or Town, State, Zip Code)  |  |  |  |  |
| _   | and 2<br>salth a<br>n 27 is   |                | Mervelyn Wyll   | ie-Brause  | 78                                       | 8 Eastern P  | oint Anna   | apolis, 1                                    | MD 2140                                 | 1  |  |  |  |
| more  | of H  |                | 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☒ Donation 5 ☐ Other  | n 3 □Removal from State (Specify)  | 20b. Place of D<br>cemetery,             | Disposition (Name of<br>crematory or other plac  | ce)   | Date   | 20c. Location - Cit                     | y or Town, State   |  |  |  |
| Dail  | permit. Page<br>Department<br>Important: If<br>any injury o   |                | 21. Signature Royal d   | e Licensee de, Dire  | ector                                    | State Anat<br>Baltimore,   | ss of Facility<br>Comy Board                            | 1 655 W.                                     | Baltimo                                 | re Street  |  |  |  |
|   | Physician   | y I            | Immediate Cause (Final  | or complications that caused<br>ist only one cause on each lin               | the death. Do no                         |  | ng, such as cardiac                                     |  | est,                                    | Approximate<br>Interval Between<br>Onset and Death                               |  |  |  |
|   | /Medical  |                | disease or condition resulting in death)  | a. Due to (or sa   | a consequence of)                        |  |   |  |   | > aax>   |  |  |  |
|   | Examiner  | Je.            | Sequentially list conditions,   | bisc.  | hemic                                    | bower  | /   |  |   | 1 week   |  |  |  |
|   | ecuted<br>and<br>-transit   | Examiner       | Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | - Per  | ipher a consequence of)                  | al arte  | ry di   | 58958  |   | 10 years   |  |  |  |
| 8/00,   | ficate be executed<br>physician and<br>sthe burial-transit  | edical E       |   | d. Die   | abetes                                   | mellit   | vs, 7   | 1991   |   | 20 x 89 5  |  |  |  |
| O. BOX 6  |   | Physician/Med  | IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown   | 23c. If yes, outcome particle 1  | 2 Fetal death                            | 3 □Ectopic pregnancy<br>5 □ Other (specify)  | ,   |  | 23d. Date o<br>Month                    |  |  |  |  |
| 7.  | res that the igned by be detact   | by Ph          | Part II. Other significant condi  | ite to the cause of death?   |  |  |   |  |   |  |  |  |  |
| 0   | requi   | eted           |   |  |  |  |   | 1 ☐ Ye                                       | s 21 No 3[                              | Probably 4 Unknown   |  |  |  |
|   | The law<br>ate has b<br>page 2 s  | Completed      |   |  |  |  |   | 24a. Was ar<br>autops<br>perforn<br>1∐ Yes 2 | y prio<br>ned? dea                      | re autopsy findings available<br>ir to completion of cause of<br>th?<br>Yes 2 No |  |  |  |
| N II  | lcian:<br>certific<br>ector,  | Be             | 25. Was case referred to medic examiner?  | 1  |  | Lous   |   | h Check onl one                              | ,                                       |  |  |  |  |
| 5   | Phys<br>r this<br>ral dir   | . To           | 1 ☐ Yes 2 No<br>27. Manner of Death   | Hospital: 1 Inpatier<br>28a. Date of Injur                                   |  | atient 3 DOA Othe  | 4 □ Nursing Ho  | ome 5 Reside                                 | nce 6 Other (                           | (Specify)  |  |  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed bear within 24 hours after death. | nding<br>th.<br>:: Afte<br>e fune   | tion           | 1 Natural 5 ☐ Pend  |  |  | ıry Worl   | k?<br>Yes 2 □ No  | 200. Describe no                             | w injury occurred                       |  |  |  |  |
|   | after dea<br>Director   | Certification: | 3 Suicide 6 Could   | d not be mined 28e. Place of inju building, etc                              | ry - At home, farm<br>. <i>(Specify)</i> | , street, factory, office  |   | 28f. Location (Str<br>City or Town           |   | or Rural Route Number,   |  |  |  |
|   | e Hospita<br>24 hours<br>e Funeral<br>etely filled  | Medical C      | 29a. Certifier 1 Certify (Check only one) 2 Medica  | ring Physician: To the best of al Examiner: On the basis of and manner state | examination and/                         | death occurred at the tin<br>or investigation, in my o                                     | ne, date and place,<br>pinion, death occur              | and due to the ca<br>red at the time, da     | ause(s) and manne<br>ate and place, and | er as stated. I due to the cause(s)  |  |  |  |
|   | To the within To the compl  | Me             | 29b. Signature and title of certifi   | ier 1 1  |  | 29c. License   | e number  | 29   | d. Date signed (A                       | Month, Day, Year)  |  |  |  |
| )   |   |                | Marl  | 19. 12ene  | y My                                     | 00   | 102957  | 1  | 05/22                                   | /2008  |  |  |  |
|   |   |                | 30. Name and address of perso 225 E 0 e 1 31. Date filed (Month, Day, Yea, MAY 3 C  | n who completed cause of de  | eath (Item 23a) (T                       | ton, MD  | 21114   | Pavi   | B. Be                                   | erez mo  |  |  |  |
|   | Sta<br>Registr  | ite<br>ar      | 31. Date filed (Month, Day, Yea.  | 7) 2008 32 Registra  | r's Signature                            | parte  |   |  |   |  |  |  |  |

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

**Physician** /Medical Examiner **Funeral** Director an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at Director death v Funeral hours after Baltimore, Maryland 21215-0036 þ Completed within 72 in a 12 should be filed w h and Mental Hygiel 7 Is marked other th Department of Health and Labertment of Health and Important: If item 27 is my any injury or other once. **Physician** /Medical **Examiner** 

2. Date of Death 1. Decedent's Name (First, Middle, Last) BENNETT 8:30 AM IRENE 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not Institution, give street and number) JOHNS HOPKINS BAYVIEW MEDICAL CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 01/22/1916 9. Birthplace (State or Foreign 6 Sex Days 1 □ M 2 🔀 F Maryland 216-36-9485 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2XX Maryland | Baltimore Middle River 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21220 846 Seneca Park Road Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: 3XXWidowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Sales Associate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Drayer Catherine Helldorfer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony Bennett (Son) 940 Susquehanna Avenue, Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Removal from State Gardens Of Faith May 31,2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Eacility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 21. Signature of Funeral Service Licensee 23a. Part1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, theart failure. List only one cause on each line. shock, eart failt Immediat ause (Final diseas r condition resulti in death) DAYS PNELLMONIA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical attending IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4□Pregnant at time of death 5 ☐ Other (specify) Division or Vital Records, P.O. the 9□Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 BLEED INTRACRANTAL 1 ☐ Yes 2 No 3 Probably 4 Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No HYPERTENSION 24a. Was an has autopsy performed? 1☐ Yes 2 1 page 2 certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide after To the Hospital or within 24 hours at To the Funeral C filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MAY 27, 2008 RES-000 RAYA MASSOUD . (<u>L.P</u>. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN AVENUE BALTIMORE, MD 21824 MASSOLD 4940 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAY 3 0 Registrar

|                                |  |                     | 1 - For<br>State<br>Registrar   | State of Maryland   |                          | artment of Hertificate of L                                       |   | Re                                      | eg. No. 2008                                      |   |
|--------------------------------|--|---------------------|---|---|--------------------------|---|---|---|---|---|
|                                | Physici  | an                  | Decedent's Name (First, Middle, Last  | an T. Bates   |                          |   |   | 2. Date of Deat<br>Month                | Day Year 24 2008                                  | 3:30 p M  |
|                                | /Medic<br>Examin   |                     | 4a. Facility Name (If not institution, give   |   |                          | 4b. City, Town, or  | Location of Death                           |   | 4c. County of Dea                                 |   |
|                                |  |                     | Augsburg N/H  |   | A falled and a six       | Gwynn C   | a k<br>If Under 24 Hrs.                     | 8. Date of Birth                        | Balto   | hplace (State or Foreign  |
|                                | Funeral<br>Director  |                     | 5. Social Security Number 6. Security Number 11   | 7. Age (In yrs. las   | Yrs.                     | Months Days   | Hours Min.                                  | (Month, Day,                            | Year) Co  | GA  |
|                                | ס  |                     | Usuel Residence of Decedent  10a. State 10b. County                                     | 10c. City,  | Town or Lo               | cation  |   |   |   | 10d. Inside City Limits   |
|                                | Maryla<br>febo   | to                  | MD N/   |   |                          |   |   |   |   | 1 ☐ Yes 2 ☐ No  |
|                                | or 28a   | lrec                | 10e. Street and Number  | A Dai   |                          | 10f. Zip Code   |   | 1                                       | 0g. Citizen of What Co                            | ountry?   |
|                                | eth wi   | ral                 | 4512 White Oak  |   | 12                       |   | 21215                                       |   | U S A   | erican Indian   |
| 39                             | urs after de<br>al', or Item   | by Funeral Director | 11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced             | 12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 No If Yes, Give Year or Dates:               |                          | Was Decedent of Hi<br>If Yes, specify Cubai<br>1 ☐ Yes 2☐XNo      | Specify:                                    | Rican, etc.)                            | Black, Whit                                       |   |
| Baltimore, Maryland 21215-0036 | mit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland purtnent of Health and Mental Hygiene. Portant: If Item 23 ie marked other then "natural; or Iteme 23a or 28a-f ehow y njury or other traumatic event; the Madical Examinating the multilised at the notified at the contraction of the profiled at the contraction of the profiled at the contraction of the profiled at the contraction of the profiled at the contraction of the profiled at the contraction of the profiled at the contraction of the profiled at the profiled at the profile of the profiled at the profile of the profi | Completed           | 15. Decedent's Ed<br>(Specify only highest grad<br>Elementary/Secondary (0-12)          | de completed) College (1-4or 5+)  | (Give<br>life.           | dent's Usual Occupa<br>kind of work done d<br>DO NOT use retired, | luring most of workii<br>)                  |   | 16b. Kind of Business                             | <sup>/Industry</sup> Unk  |
| d 21                           | Hygier<br>ther th  |                     | 12th grade 17. Father's Name (First, Middle, Last)                                      | N/A   | S                        | eamstres  | 18. Mother's Name                           | (First, Middle, I                       | Maiden Sumame)                                    |   |
| <u>lan</u>                     | Aental<br>Aental<br>rked o   | To Be               | George Thornto  | n   |                          |   | Minnie                                      | L. Sa                                   | unders  |   |
| lary                           | 2 short  |                     | 19a. Informant's Name/Relationship  | ype, Print)<br>randdaughter   |                          |   |   |   | r, City or Town, State,                           |   |
| ē,                             | Health<br>tem 27<br>other t  |                     | Angela M. Marti 20a. Method of Disposition  | 20b. Plac   | e of Dispo               | Denison<br>osition (Name of<br>matory or other place              |   |   | MD 2122   |   |
| Ë                              | Pages<br>nent of<br>ant: If<br>ury or  |                     | ty⊡Burial 2 ☐ Cremation 3 ☐<br>4 ☐ Donation 5 ☐ Other (Specify                          | Removal from State  | -                        | Memoria   |   | -2008_                                  | Arbutus,  | MD  |
| Balt                           | Print.   |                     | 21. Signature of Funeral Service Licen  |   | 2:                       | 2. Name and Addres  | s of Facility M                             |   | /H East   | 21202   |
|                                | 40204  |                     | 23a. Part 1. Enter the disease, or comp   |   |                          |   |   |   | est, MD   | Approximate<br>Interval Between                                       |
|                                | Physician  |                     | shock, or heart failure. List only of<br>Immediate Cause (Final<br>disease or condition | one cause on each line.   | 7                        | Izhaina   | > dise                                      | <del>વક</del> ્ટ                        |   | Onset and Death   |
|                                | /Medical<br>Examiner   |                     | resulting in death)   | Due to (or as a conseque  | nce of):                 | \-\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \                           |   |   |   |   |
|                                | - 8-   | ner                 | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying      | b. Due to (or sit a conseque  | nea of)                  |   |   |   |   |   |
| V                              | eath certificate be executed attending physicien and for use as the burial-transit   | Examiner            | Cause (Disease or injury that initiated events resulting in death) Last                 | c.  Due to (or as a conseque  | nce of):                 |   |   |   |   |   |
| 68760,                         | e be e)<br>/sicien<br>e buria  | cal E               |   | d   | ,                        |   |   |   |   |   |
| 89                             | ntificat<br>ing phy<br>e as th   |                     | IF FEMALE:  | -   | _                        |   | ME.   |   | 10000   |   |
| P.O. Box                       | 0 0  | Physician/Med       | 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown            | 23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d 4 ☐ Pregnant at time of dea 9 ☐ Unknown | eath 3[                  | Ectopic pregnancy Other (specify)                                 |   |   | 23d. Date of de<br>Month                          | olivery<br>Day Year   |
|                                | law requires that the<br>as been signed by th<br>2 should be deteche   | á                   | Part II. Other significant conditions of  | ontributing to death but not result   | ing in the u             | inderlying cause give   | en in Part I.                               |   | bacco use contribute<br>es 2 <del>M</del> o 3 ☐ F | to the cause of death?  |
| I Records,                     | The<br>ete h<br>page   | Completed           |   |   |                          |   |   | 24a. Was a<br>autop<br>perfor<br>1  Yes | sy prior to                                       | utopsy findings available<br>completion of cause of<br>s 2 \sumbed No |
| of Vital                       | Physician: 1<br>r this certificel<br>ral director, p   | Be                  | 25. Was case referred to medical examiner?  | Hospital:   |                          | - act on Oth  | 26. Place of Death                          |   |   |   |
| ō                              | ding Phye<br>h.<br>After this<br>funeral di  | 5 E                 | 1 ☐ Yes 2 No<br>27. Manner of Death   | 1   Inpatient 2   E   | 8b. Time of<br>Injury    | nt 3LI DUA  | 4TS Nursing no                              |   | ence 6 Other (Sp<br>ow injury occurred            | ecity)  |
| sion                           | Attending<br>r death.<br>ector: Aftel<br>by the fune   | catlo               | 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be                   |   |                          | M 1 🗆   | Yes 2□No                                    |   |   |   |
| Division                       | l or Att<br>after d<br>Direct<br>I in by   | Certification;      | 3 Suicide 6 Could not be<br>4 ☐ Homicide determined                                     | 28e. Place of Injury - At hom building, etc. (Specify)  | ie, farm, si             | reet, factory, office   |   | City or Tow                             | itreet and Number or F<br>n, State)               | surai Houte Number,   |
|                                | To the Hospital or Attendi<br>within 24 hours after death.<br>To the Funeral Director: A<br>completely filled in by the fo   | edical C            | 29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam                         | ysician: To the best of my know<br>niner: On the basis of examination<br>and manner stated.         | edge, dea<br>on and/or i | th occurred at the tin  | ne, date and place,<br>pinion, death occurr | and due to the o                        | cause(s) and manner a<br>date and place, and du   | is stated.<br>le to the cause(s)                                      |
| /                              | To th<br>To th<br>comp   | Me                  | 29b. Signature and title of certifier   |   | $\overline{}$            | 29c. Licens   |   |   | 29d. Date signed (Mor                             |   |
| •                              | ħ  |                     | 20 No.  | completed cause of death (lies  | (32) /T                  | Print   | D375<br>Rester                              | 1>                                      | May 2.  | 8,2008  |
|                                | 2  |                     | 30. Name and address of person who  | MD SZ   | Mo                       |   | Rester                                      | rstown                                  | MD  | 21136   |
|                                | St<br>Regist   | ate<br>rar          | 31. Date filed (Month, Day, Year)<br>MAY 3 0 2008                                       | 32. Registrar's Signatu   | Loss                     |   |   |   |   |   |

P.O. Box 68760

May 24, 2008

Ronald

Division of Vital Records,

sate has been signed by page 2 should be detact To the Hospital or Attend within 24 hours after death. To the Funeral Director;

with the Maryland

death v

Pages 1 and 2 should be filed within 72 hours after

Baltimore, Maryland 21215-0036

| Part II. Other significant conditions  CONGESTIVE HE                 | contributing to death but not resulting in the underlying cause given in Part I.                | 23e. Did tobacco use contribute to the cau                             |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|--|
| HEPATITIS B  | , HEPATITIS C   | 24a. Was an autopsy fi prior to complet death? 1 □Yes 2 ▼No 1 □Yes 2 □ |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?                           | 26. Place of Death (Check only one)   |  |  |  |  |  |  |  |  |
| 1 Yes 2 No   | Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing                          | Home 5 ☐ Residence 6 ☐ other (Specify)                                 |  |  |  |  |  |  |  |
| 27. Manuar of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation | 28a. Date of Injury (Month, Day, Year)  28b. Time of lnjury 28c. Injury at Work? 1 □ Yes 2 □ No | 28d. Describe how injury occurred                                      |  |  |  |  |  |  |  |
| 3 ☐ Suicide 6 ☐ Could not to determined                              |   | 28f. Location (Street and Number or Rural Rou<br>City or Town, State)  |  |  |  |  |  |  |  |
| 29a. Certifier 1 Certifying P  | hysician: To the best of my knowledge, death occurred at the time, date and plan                | ce, and due to the cause(s) and manner as stated                       |  |  |  |  |  |  |  |

29b. Signature and title of certific

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0026327

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOUGLAS 31. Date filed (Month, Day, Year) MAY 3 0 2008 6114 CAMPFIRE, COLUMBIA MD 21045

Registrar DHMH 17 Rev 1/2001

State

08-04061 Anthony Bass Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

| nthony Bass   |                 | or State  | ate of Maryla          | and / Depar<br><i>Cert</i>       | tment of<br>ificate of      | Health ar<br><i>Death</i> | nd Me             | ental F               |                             | Reg. No            |                 | 200            | 8 1749   |
|---|-----------------|---|------------------------|----------------------------------|-----------------------------|---------------------------|-------------------|-----------------------|-----------------------------|--------------------|-----------------|----------------|--|
| Physician/  | Red             | uistrar<br>Decedent's Name (First, Middl                          | e,Last)                |                                  |                             |                           |                   |                       | Date of De     Month        |                    | Year            | -              | Time of Death  1402 hrs                          |
| lediçal Examine   |                 | ANTHONY BA  | SS                     |                                  |                             |                           |                   | 1.00                  | Month<br>May 27,            |                    | c. County o     | f Death        |  |
| W.  | 4a              | 4a. Facility Name (if not institution, give street and number)    |                        |                                  |                             | b. City, Town, o          |                   | Baltimore County      |                             |                    |                 | ty             |  |
|   |                 | Northwest Regional H  |                        |                                  | - ( ) - i ad ba ad an a ( ) | If Under 1 Ye             |                   | Under 24H             | rs. 8 Date of B             | Birth (MN          | //DD/YYYY       | 9. Birthp      | place (State or                                  |
| Funeral   | 5.              | Social Security Number  | 6. Sex                 | 7. Age (In yrs. las              | st birthday)                |                           |                   | lours Mi              |                             |                    |                 | Foreign        | try) MARYLAND                                    |
| Director  |                 | 215-80-5141   | 1X M 2 F               | 47                               | Yrs.                        |                           |                   |                       | 11-3                        | 0-1                | 700             |                | ,,   |
|   |                 | sual Residence of Decedent  |                        | 10c City                         | Town or Locati              | on                        |                   |                       |                             |                    |                 | 1              | 0d. Inside City Limits                           |
| w any   | 10              | a. State 10b. County  |                        |                                  | ALTIMOR                     |                           |                   |                       |                             |                    |                 |                | 1 X Yes 2 No                                     |
| Aaryland 28a-f show 1 at once.  | iL              | MD. N   | <u> </u>               | D                                | ALITHON                     | 10f. Zip Code             |                   |                       |                             | 10g. C             | itizen of Wi    | nat Countr     | γ?   |
| the Maryland to 28a-f sh  | 10              | De. Street and Number 2116 LORRAIN                                | Z ANE                  |                                  |                             | 212                       |                   |                       |                             |                    | USA             |                |  |
| - 25  |                 |   |                        | cedent Ever in U.S               | c 113 Wa                    | s Decedent of             | Hispanio          | c Origin? (           | Specify Yes or              | No-                |                 |                | an Indian, Black,                                |
| r death with or items 23  | 1 1             | 1. Marital Status  Never Married 2 N                              | Married Armed F        | Forces?                          | If Y                        | es, specify Cub           | an, Mex           | xican, Puet           | to Rican, etc.)             |                    | White           | e, etc.        |  |
| or it   | 3 (             |   | 1 Yes                  | 2 No                             | 1                           | Yes 2 X                   | No spe            | ecify:                |                             |                    | Specify:        | BLA            | ACK  |
| s afte  | ∑ —             | Widowed 4 X Di<br>15. Decedent's Education (Spe                   |                        |                                  | 16a. Deceder                | t's Usual Occu            | pation (          | Give kind o           | of work done                | 16t                | . Kind of Bu    | ısiness/In     | dustry   |
| "nate   |                 | Elementary/Secondary (0-12  |                        | (1-4 or 5+)                      | during m                    | ost of working l          | lite. DO          | NOT use i             | elireu)                     | - 1                |                 |                |  |
| within 72 hours giene. her than "natu   |                 | -12-  |                        | 2-                               | MEC                         | CHANIC                    |                   |                       |                             |                    | DIESE           | L ME           | CHANICS  |
| 5-0036 led within 72 hou digiting the within 72 hou other than "nat the Medical Exa   | <u> </u>        | 7. Father's Name (First, Middle                                   |                        |                                  |                             |                           | 18.M              | other's Na<br>T. I    | me (First, Middl            | e, Maid<br>F.T.T.Y | en Surname<br>, | <del>)</del> ) |  |
| 1215<br>Id be file<br>Aental H.<br>narked o<br>event, th  | וא              | LEAMON BASS   |                        |                                  |                             |                           | 1_                |                       | or Rural Route              |                    |                 | vn State       | Zin Code)  |
| re, MD 21215-0036 s 1 and 2 should be filed within 7 filealth and Mental Hygiene. If item 27 is marked other than TO DE COMPAN  |                 | 9a. Informant's Name/Relation                                     | ship (Type, Print )    | лапсн <b>т</b> ер                |                             | 9 Address (SI<br>316 HAYI | treet and<br>WARD | O AVE                 | BALTI                       | MORE               | MAR             | YLAN           | D 21215  |
| ages I and 2 shou nt of Health and N tt: If item 27 is not the traumatic  |                 | MARCELLE BAS  | 2-MIT20W(              | Look                             |                             | sition (Name of           |                   |                       | Date                        |                    |                 |                | Fown, State                                      |
| re, M<br>1 and 2<br>f Health<br>If item 2<br>er traum   | - 1             | Oa. Method of Disposition  Burial 2 Crematic                      | on 3 Removal           | C Ct-t-                          | crematory or of             | ther place)               |                   | 1                     | -30-200                     | 8 F                | SALTIN          | ORE.           | MARYLAND   |
|   |                 | Donation 5 Other  | Specify:               | Pi                               |                             | REMATOR                   |                   |                       |                             |                    |                 |                |  |
| Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other tr  | 2               | 21. Signature o Funeral Service                                   | ce License JONA        | THAN O                           | HIBNER                      | Name and Add              | ress or r         | P                     | HILLIPS                     | FUN                | IEKAL           | HUME           | , P.A.   |
| <b>a</b> §9 [ [   | 1               | 23a. Part. Ther the disease,                                      | M C                    | - True                           | Do not enter                | <u>1721–27</u>            | N.                | MONKO<br>th as cardia | OE ST.<br>ac or respiratory | BAL<br>arrest,     | shock, or h     | eart           | RYLAND 2121/<br>Approximate Interval             |
| Physician (   | 2               | failur - List only one caus                                       | se on each line.       |                                  |                             | ,                         |                   |                       |                             |                    |                 |                | Between Onset and<br>Death                       |
| aminer  |                 | Imme e Cause (Final diseas<br>or condition resulting in death)    |                        | ic ketoacio<br>s a consequence o |                             |                           |                   | _                     |                             |                    |                 |                | 78722  |
|   | 1               | or condition resulting in deading                                 | b Due to (or as        | s a consequence o                | 51).                        |                           |                   |                       |                             |                    |                 |                |  |
|   |                 | Sequentially list conditions, if any, leading to immediate        |                        | s a consequence o                | of):                        |                           |                   |                       |                             |                    |                 |                |  |
|   | 틹               | cause. Enter Underlying Caus<br>(Disease or injury that initiated | Dua 40 (07.0           | s a consequence                  | of):                        |                           | _                 | _                     |                             |                    |                 |                |  |
| 1 g _ g / (1)   | الس             | events resulting in death) Las                                    | t Due to (or a         | a consequence                    | 0.,.                        |                           |                   |                       |                             |                    |                 |                |  |
| and and   | dical           | X UNPENDED  | AMENDE                 | D <sub>0.7</sub> ME              | .000 6/2                    | /O0 mm                    |                   |                       |                             |                    |                 |                |  |
| O,<br>e be ex<br>ysician<br>burial  | $\omega \vdash$ | IF FEMALE:  |                        | 27 perME,                        |                             | 06_11_                    |                   |                       |                             |                    | 23d. Date       |                |  |
| 876<br>tificat<br>ng ph   | <u>⋛</u>  2     | 23b. Was decedent pregnant in<br>past 12 months?                  | the 1 Liv              | e birth                          | 2 F                         | etal death                | 3                 | Ectopic pro           | egnancy                     |                    | Month           | ı              | Day Year   |
| X 6   | <u>::</u>       |   |                        | egnant at time of d              | leath 5 (                   | Other (Specify)           |                   |                       |                             | -                  |                 |                | - 1  |
| Records, P.O. Box The law requires that the death cate has been signed by the atte page 2 should be detached for t  | -               | Part II. Other significant con                                    | 9011                   | known                            | resulting in the            | underlying ca             | use give          | en in Part I          | . 23e.                      | Did toba           | cco use co      | ntribute to    | the cause of death?                              |
| b.O.  | 5               | Part II. Other Significant con                                    | Commoditi              | 9 10 00001 021 1111              |                             | , -                       |                   |                       | 1                           | Yes                | 2 No            | 3 Pro          | bably 4 🗹 Unknown                                |
| S, F<br>puires<br>on sign   |                 |   |                        |                                  |                             |                           |                   |                       |                             | Was an             |                 | . Were a       | utopsy findings available completion of cause of |
| ord<br>Iw req<br>as bee   | Ped             |   |                        |                                  |                             |                           |                   |                       | _                           | autopsy<br>perform | ed?             | death?         |  |
| Rec<br>The Is<br>cate h   | Completed       |   |                        |                                  |                             |                           | DI                | (Death (Ch            | neck only one)              | Yes 2              | NO              | 1 🗸 Y          | 65 2 110   |
| ian:<br>lan:<br>certifi   | B B             | 25. Was case referred to med examiner?                            | lical Hospital:        | Inpatient 2                      | € CD/Outpatic               |                           | Tot               |                       | lursing Home                | 5 R                | esidence (      | 6 Othe         | er;  |
| Vit   | 힑               | 1 Yes 2 No  | 1                      | ate of Injury                    | 28b. Time of                |                           |                   | at Work?              |                             |                    | w injury occ    | urred          |  |
| Jing F  |                 | 27. Manner of Death  1 X Natural 5 P                              | ending (M              | onth, Day, Year)                 |                             |                           | Ye:               | s 2 N                 | 0                           |                    |                 |                |  |
| Sior<br>Mitenc<br>death<br>death<br>sy the  | ۱ğ              |   |                        | Place of Injury - At             | home, farm, st              | reet, factory, of         | ffice buil        | lding, etc.           |                             |                    |                 | mber or R      | tural Route Number, City                         |
| Division of Vital Records, P.O. tal or Attending Physician: The law requires that the sa ther death.  "at Director: After this certificate has been signed by lled in by the funeral director, page 2 should be detach.   | Certification:  | Salicide d  | could not be   Special |                                  |                             |                           |                   |                       | or To                       | own, Sta           | ite)            |                |  |
| Cospita<br>hours<br>unera<br>y fille  |                 | 4 Homicide 29a. Certifier 1 Certifying                            |                        |                                  | edge, death oc              | curred at the tir         | me, date          | e and place           | e, and due to the           | e cause            | (s) and mar     | ner as sta     | ated.  |
| Division of Vital Records, P.O. Box 6876C To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b | Medical         | (Check only one) 2 Medical 1                                      | Examiner: On the ba    | isis of examination              | and/or investi              | gation, in my o           | pinion, c         | death occu            | rred at the time            | , date a           | na piace, ai    | 10 000 10 1    |  |
| To To com   | Med             | 29b. Signature and title of ce                                    | and main               | ici Stateu.                      |                             |                           |                   | number                |                             |                    | 29d. Date s     | signed (M      | onth, Day, Year)                                 |
|   | ***             | Op 2 de   | HALL                   | lair                             |                             |                           | O.C.M             | 1.E.                  |                             |                    | May 28,         | 2008           |  |
| 18. C   |                 | 30. Name and address of per                                       | rson who completed     | cause of death (It               | em 23a)                     |                           |                   |                       |                             |                    |                 |                |  |
| oth   |                 | Carol Allan, MD   | Assistant Medi         | cal Examiner                     | 111 Pen                     | n Street, Ba              | altimo            | re, MD 2              | 21201                       |                    |                 |                |  |
| St  | ate             | 31. Date filed (Month, Day, Ye                                    | 7hn8 43                | 2. Registrar's Sign              | ature                       | les .                     |                   |                       |                             |                    |                 |                |  |
|   |                 | MINI OF U   | ALUUU SUULA            | WITHING AND                      | AND AND THE PARTY OF        | PART                      |                   |                       |                             |                    |                 |                |  |

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** anne 2008 25 /Medical Town, or Location of Death ility Name (If not institution, give street and number) **Examiner** west If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🖾 F Months Days Min AUG. 10, Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notifled at 1 XYes 2 □ No BALTTMORE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21213 1809 RUTLAND AVE Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【★No If Yes, Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married BLACK 1 ☐ Yes 2 🖾 No altimore, Maryland 21215-0036 Specify ð 3 XWidowed 4 ☐ Divorced ear or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PUBLIC SCHOOLS **EDUCATOR** th and Mental Hygiei 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event once, Be **GENEVA** DENNIS JONES 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 E. BIDDLE ST. - APT. #112, BALTIMORE, MD ELDRIDGE BRANCH 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATIONAL 05/31/2008 | LAUREL, MD 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Service Licens 2007-09 EASTERN AVE., BALTIMORE, MD 21231 23a. Part1. Enter the disease, or complications trut caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused neach line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nijury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Physician/Medical the IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2□ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2[**N**0 1 npatient 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of injury 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day 1 Natural 2 Accident 5 Pending investigation

P.O. Box 68760, Division or Vital Records,

Hospital or Attending Physician: After t after death Director: filled in by hin 24 hours a the Funeral I within 24 hor To the Function

State Registrar

6 ☐ Could not be

determined

3 Suicide

29a. Certifier

Medical

4 Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

🗲 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

d address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Steven Fullow

Date filed (Month, Day, Year) 2008 2 9

